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State/Territory Name: MI 1915i for Behavioral Health
State Plan Amendment (SPA) #: 19-0006

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
233 N. Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

Regional Operations Group

September 27, 2019

Kate Massey, Medicaid Director
Medical Services Administration
Michigan Department of Health and Human Services
400 South Pine Street, P.O. Box 30479
Lansing, Michigan 48909-7979

ATTN: Erin Black

Dear Ms. Massey:

This letter serves as the Centers for Medicare and Medicaid Services (CMS) approval letter for Michigan TN 19-0006: 1915(i) Behavioral Health: This State Plan Amendment will authorize the provision of Community Supports Services to Medicaid beneficiaries with a serious emotional disturbance, serious mental illness and/or intellectual/developmental disability.

- Effective Date: October 1, 2022
- Approval Date: September 27, 2019

Since the state has elected to target the population who can receive these §1915(i) state plan home and community based services, **CMS approves this SPA for a five-year period** in accordance with §1915(i)(7) of the Social Security Act. To renew the §1915(i) benefit for an additional five-year period, the state must submit a renewal application to CMS at least 180 days prior to the end of the approval period. CMS' approval of a renewal request is contingent upon state adherence to federal requirements and the state meeting its objectives with respect to quality improvement and beneficiary outcomes.

The Code of Federal Regulations ("CFR"), 42 CFR §441.745(a)(i), requires the state to annually provide CMS with the projected number of individuals to be enrolled in the benefit and the actual number of unduplicated individuals enrolled in the §1915(i) state plan HCBS in the previous year. Additionally, at least 18 months prior to the end of the five-year approval period, the state must submit evidence of its quality monitoring in accordance with the Quality Improvement Strategy included in their approved SPA. The evidence must contain data analysis, findings, remediation, and describe any system improvement for each of the §1915(i) requirements.

If you have any questions, please contact Keri Toback at (312) 353-1754 or keri.toback@cms.hhs.gov.

Sincerely,

/s/
Ruth A. Hughes
Deputy Director
Center for Medicaid and CHIP Services
Regional Operations Group

Enclosure

cc: Erin Black, MDHHS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTHCARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 19 - 0006

2. STATE: Michigan

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH FINANCING ADMINISTRATION
DEPARTMENT OF HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2022

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1915(i) of the Social Security Act and 42 CFR Part 441 Subpart M

7. FEDERAL BUDGET IMPACT:
a. FFY 2023 $0
b. FFY 2024 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 2.2-A, Pages 26d and 26e
Attachment 3.1-i.2, Pages 1 through 70
Attachment 4.19-B, Page 27 and 28

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
N/A – New Pages

10. SUBJECT OF AMENDMENT:
This 1915(i) SPA will authorize the provision of Community Supports Services to Medicaid beneficiaries that are currently provided as Section 1915(b)(3) services under the Managed Specialty Services and Supports Program.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Kate Massey, Director
Medical Services Administration

12. SIGNATUE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Kate Massey

14. TITLE:
Director, Medical Services Administration

15. DATE SUBMITTED:
August 1, 2019

16. RETURN TO:
Medical Services Administration
Actuarial Division - Federal Liaison
Capitol Commons Center - 7th Floor
400 South Pine
Lansing, Michigan 48933

Attn: Erin Black

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
August 1, 2019

18 DATE APPROVED:
September 27, 2019

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 2022

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPE NAME:
Ruth A. Hughes

22. TITLE:
Deputy Director

23. REMARKS:

Groups Covered

Optional Groups other than the Medically Needy

In addition to providing State plan HCBS to individuals described in 1915(i)(1), the state may **also** cover the optional categorically needy eligibility group of individuals described in 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the FPL, or who are eligible for HCBS under a waiver approved for the state under Section 1915(c), (d) or (e) or Section 1115 (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate. See 42 CFR § 435.219. (*Select one*):

☑ No. Does not apply. State does not cover optional categorically needy groups.

☐ Yes. State covers the following optional categorically needy groups. *(Select all that apply):*

(a) ☐ Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services. There is no resource test for this group. Methodology used: *(Select one):*

☐ SSI. The state uses the following less restrictive 1902(r)(2) income disregards for this group. (*Describe, if any*):

☐ OTHER (*describe*):

(b) ☐ Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate. Income limit: (*Select one):*

☐ 300% of the SSI/FBR

☐ Less than 300% of the SSI/FBR (*Specify):* _____%

Specify the applicable 1915(c), (d), or (e) waiver or waivers for which these individuals would be eligible: *(Specify waiver name(s) and number(s)):*

(c) ☐ Individuals eligible for 1915(c), (d) or (e) -like services under an approved 1115 waiver. The income and resource standards and methodologies are the same as the applicable approved 1115 waiver.

Specify the 1115 waiver demonstration or demonstrations for which these individuals would be eligible. *(Specify demonstration name(s) and number(s)):*

1915(i) State Plan Home and Community-Based Services Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit *for elderly and disabled individuals as set forth below.*

1. Services. *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

Community Support Services: Community Living Supports, Enhanced Pharmacy, Environmental Modifications, Family Support & Training, Fiscal Intermediary, Housing Assistance, Respite Care, Skill-Building Assistance, Specialized Medical Equipment & Supplies, Supported/Integrated Employment, and Vehicle Modification.

2. Concurrent Operation with Other Programs. (*Indicate whether this benefit will operate concurrently with another Medicaid authority)*: ***Select one*:**

○	**Not applicable**
X	**Applicable**

Check the applicable authority or authorities:

☐	**Services furnished under the provisions of §1915(a)(1)(a) of the Act.** The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:* *(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);* *(b) the geographic areas served by these plans;* *(c) the specific 1915(i) State plan HCBS furnished by these plans;* *(d) how payments are made to the health plans; and* *(e) whether the 1915(a) contract has been submitted or previously approved.*
☐	**Waiver(s) authorized under §1915(b) of the Act.** *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*

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

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

☐	**A program operated under §1932(a) of the Act.** *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*
X	**A program authorized under §1115 of the Act.** *Specify the program*: The §1915(i) State Plan Amendment will operate concurrently with the §1115 Behavioral Health Demonstration Waiver for the purpose of managed care. In addition, the §1115 bestows authority for a three year period, for the process change to come into compliance with the eligibility determination

	requirements for the Medicaid 1915(i) HCBS state plan benefit, which will sunset effective 10/1/2022.

3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. *(Select one)*:

X	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:		
	○	The Medical Assistance Unit *(name of unit)*:	
	☑	Another division/unit within the SMA that is separate from the Medical Assistance Unit	
		(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	Michigan Department of Health and Human Services (MDHHS)/Behavioral Health and Developmental Disabilities Administration (BHDDA).
○	The State plan HCBS benefit is operated by *(name of agency)*		
	a separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.		

4. Distribution of State plan HCBS Operational and Administrative Functions.

X *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☐	☑	☐
2 Eligibility evaluation	☑	☑	☐	☐
3 Review of participant service plans	☑	☐	☑	☐
4 Prior authorization of State plan HCBS	☑	☐	☑	☐

5 Utilization management	☑	☐	☑	☐
6 Qualified provider enrollment	☑	☐	☑	☐
7 Execution of Medicaid provider agreement	☑	☐	☑	☐
8 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☐	☐
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☐	☐	☐
10 Quality assurance and quality improvement activities	☑	☐	☑	☑

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

Contracted Entity: MDHHS/BHDDA, as the ***Medicaid State Agency,*** will maintain accountability, directly perform, and/or otherwise monitor all administrative functions of the state plan HCBS benefit. MDHHS local field offices establish Medicaid eligibility (function 2) as ***the other state agency*** and MDHHS/BHDDA contracts with regional managed care Pre-paid Inpatient Health Plans (PIHP), as the ***other contracted entity***, to assist in monitoring functions of the HCBS benefit (functions 1, 3, 4, 5, 6, 7, and 10). MDHHS/BHDDA, the PIHP, an EQR Vendor, and **local non-state entities/**Community Mental Health Service Programs (CMHSP) will all be actively involved in assuring quality and implementation of identified quality improvement activities (function 10).

(By checking the following boxes the State assures that):

5. ☑ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

MDHHS/BHDDA as the state Medicaid agency will deliver 1915(i) SPA services through contracted arrangements with its managed care PIHPs regions. The PIHPs have responsibility for monitoring person-centered service plans and the network's implementation of the 1915 (i) SPA services, which require additional conflict of interest protections including separation of entity and provider functions within provider entities.

The right of every individual receiving public mental health services in Michigan to the development of an individual plan of services and supports using the person-centered planning process is established by law in Chapter 7 of the Michigan Mental Health Code. Through the MDHHS/PIHP contract, MDHHS delegates the responsibility for the authorization of the service plan to the PIHPs. The PIHPs delegate the responsibilities of plan development to CMHSP supports coordinator or other qualified staff chosen by the individual or family. These individuals responsible for the IPOS

are not providers of any HCBS for that individual and are not the same people responsible for the independent HCBS needs assessment. The CMHSPs authorize the implementation of service through a separate service provider entity. The development of the IPOS through the person-centered planning (PCP) process is led by the beneficiary with the involvement of allies chosen by the beneficiary to ensure that the service plan development is conducted in the best interests of the beneficiary. The beneficiary has the option of choosing an independent facilitator (not employed by or affiliated with the PIHP) to facilitate the planning process. In addition, the PIHP, through its Customer Services Handbook and the one-on-one involvement of a supports coordinator, supports coordinator assistant, or independent supports broker are required to provide full information and disclosure to beneficiaries about the array of services and supports available and the choice of providers. The beneficiary has the option to choose his or her supports coordinator employed by a PIHP subcontractor or can choose an independent supports coordinator (not employed directly by or affiliated with the PIHP except through the provider network) or select a supports coordinator assistant or independent supports broker. This range of flexible options enables the beneficiary to identify who he or she wants to assist with service plan development that meets the beneficiaries' interests and needs. Person-centered planning is one of the areas that QMP Site Review Team addresses during biennial reviews of each PIHP.

The MDHHS/BHDDA has several safeguards in place to assure that the independent assessment, independent eligibility evaluation, development of the Individual Plan of Service (IPOS), and delivery of 1915(i) services by the PIHP provider network are free from conflict of interest through the following:

1) The mandated separation required in the MDHHS/PIHP contract ~~that~~ assures the assessor(s) of eligibility will not make final determinations about the amount, scope and duration of 1915i services;

2) The MDHHS/PIHP contract assures the provider responsible for the independent HCBS needs assessment are separate from the case manager/supports coordinator providers responsible for the development of the IPOS;

3) All Medicaid beneficiaries are supported in exercising their right to free choice of providers and are provided information about the full range of 1915(i) services, not just the services furnished by the entity that is responsible for the person-centered service plan development. All beneficiaries are advised about the Medicaid Fair Hearing process in the Customer Services Handbook that is provided by the PIHP to the individual at the onset of services, at least annually at the person-centered planning meeting and upon request of the individual at any time. The Medicaid Fair Hearings process is available to the individual to appeal decisions made related to 1915(i) services. This may include beneficiaries who believe they were incorrectly determined ineligible for 1915(i) services; beneficiaries who believe the amount, scope, and duration of services determined through the person-centered planning process is inadequate to meet their needs; and if 1915(i) services are reduced, suspended or terminated. Adequate Notice of Medicaid Fair Hearing rights is provided at the time the person-centered plan of service is developed and Advanced Notice of Medicaid Fair Hearing rights is provided prior to any reduction, elimination, suspension or termination of services;

4) The results of the individual needs assessment, including any other historical assessment or evaluation results, may be used as part of the information utilized in developing the individual plan of services (IPOS). Oversight/coordination of the IPOS is done by a case manager or supports coordinator or other qualified staff chosen by the individual or family, is not a provider of any other service for that individual, and is not the professional/entity that completes the individual needs assessment/authorization for eligibility or services;

5) The PIHP performs the utilization management managed care function to authorize the amount, scope and duration of 1915i services. PIHP utilization management staff are completely separate from the sub-contracted staff and entities performing evaluation, assessment, planning, and delivery of 1915i services;

6) As part of its Quality Assessment Performance Improvement Plan (QAPIP), each PIHP "has mechanisms to identify and correct under-utilization as well as over-utilization" of services [MDHHS/PIHP Contract Attachment P.7.9.1]. PIHPs use a number of different mechanisms as part of utilization management to monitor for under- and over-utilization of services. For example, the PIHP may use an independent qualified clinician to review recommended 1915(i) services; UM staff may perform regular reviews to determine if authorizations and service / units utilized are tied to IPOS goals and whether services authorized / used are medically necessary and the level approved is appropriate to meet the goals in the IPOS; or collect utilization data for trending and analysis.

7) MDHHS also monitors through its site review process and the External Quality Review (EQR) to assure that 1915(i) services will be determined and delivered appropriate and free from conflict of interest. The EQR includes a standard that evaluates the PIHP's utilization management system to assure there are written criteria and procedures for making utilization decisions, mechanisms for identifying under- and over-utilization, and processes for providing Medicaid Fair Hearing notice if a service is denied, suspended, reduced or terminated. As part of the Quality Improvement Strategy, MDHHS will implement changes as needed with CMS approval if required based on the discovery, analysis and remediation of the performance measures to ensure there are no fiduciary conflicts or incentives to either over or under utilize services.

Additional Assurances in MDHHS/PIHP Contract Section 30.0 CONFLICT OF INTEREST:
The PIHP and MDHHS are subject to the federal and state conflict of interest statutes and regulations that apply to the PIHP under this contract, including Section 1902(a)(4)(C) and (D) of the Social Security Act: 41 U.S.C. Chapter 21 (formerly Section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. §423): 18 U.S.C. §207)): 18 U.S.C. §208: 42 CFR §438.58: 45 CFR Part 92: 45 CFR Part 74: 1978 PA 566: and MCL 330.1222. Self-Determination Policy and Practice Guideline (AttachmentP4.7.1) and Medicaid Services Verification – Technical Requirements (Attachment P6.4.1)

6. ☑ **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☑ **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ☑ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.**
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	10-1-2022	9-30-2023	50,000
Year 2			
Year 3			
Year 4			
Year 5			

2. ☑ **Annual Reporting.** *(By checking this box the state agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. ☑ **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. **Medically Needy** (*Select one*):

☐ The State does not provide State plan HCBS to the medically needy.
☑ The State provides State plan HCBS to the medically needy. (*Select one*):
☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services. ☑ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

1. Responsibility for Performing Evaluations/Reevaluations Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

○	Directly by the Medicaid agency
☑	By Other (*specify State agency or entity under contract with the State Medicaid agency*):
	The PIHP provider network will perform the face-to face assessments, compile required documentation, and submit findings to the MDHHS/BHDDA. The MDHHS/BHDDA will make the determination of needs-based criteria through an independent evaluation and re-evaluation.

2. Qualifications of Individuals Performing Evaluation/Reevaluation. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications)*

MDHHS staff must have a minimum of a bachelor's degree, preferably in a health or social services field. Staff are trained in the needs-based criteria outlined for these 1915(i) State Plan services and are able to evaluate documentation to determine whether each applicant meets these criteria. Staff will have access to state systems to verify that individuals are Medicaid eligible and currently residing in a HCBS setting.

3. Process for Performing Evaluation/Reevaluation. Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

For an Evaluation/Reevaluation the MDHHS/BHDDA staff will apply the needs-based criteria described in 5 below to determine whether the individual in the targeted group is eligible for 1915(i) services. The PIHPs network will utilize standardized instruments to assist in identifying level of need (i.e. LOCUS, SIS, ASAM, Gain-I0), administer other face to face assessments related to the individual's functional abilities (i.e. EFL, AFLS, other adaptive behavior/global functioning scales, etc.), and identify services and supports required to reach the expected outcomes of community inclusion and participation. The PIHPs network will provide evidence to MDHHS/BHDDA for making the needs-based eligibility determination through a Waiver Support Application (WSA) portal.

The MDHHS/BHDDA will conduct evaluations using validated instruments specific to each individual's condition that identifies the individual meets all the eligibility requirements for 1915(i) service(s).

- For children and adolescents, with SED, the Preschool and Early Childhood Functional Assessment Scale (PECFAS) and the Child Adolescent Functional Assessment Scale (CAFAS) is utilized. For children and adolescents with intellectual or developmental disability, standardized tools to identify functional abilities, adaptive behavior/global functioning, and level of support needs (i.e.DD-CGAS, Vineland, SIS-C, etc.) will be utilized.

- For adults with mental health and co-occurring mental health and substance use disorder related needs, the Level of Care Utilization System (LOCUS) is applied. For adults with intellectual or developmental disability related needs the Supports Intensity Scale (SIS) is used. Adults presenting with needs only involving substance use disorders the Global Appraisal of Individual Needs Initial (GAIN-I) Core assessment is utilized as it directly supports the American Society of Addiction Medicine (ASAM) level of care criteria that this service system is based on.

Re-evaluation is done annually. A formal review of the IPOS will occur no less that annually with the individual and any other person chosen to participate by the individual or guardian. MDHHS/BHDDA will make determination of continuing eligibility based on evidence provided by the PIHP and evaluation that the individuals still meet the needs-based criteria described in 5 below.

4. ☑ **Reevaluation Schedule**. *(By checking this box, the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ☑ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

To be eligible for 1915(i) services an individual must meet all of the following requirements:

1. Have a substantial functional limitation in 1 or more of the following areas of major life activity:
   (A) Self-care.
   (B) Communication.
   (C) Learning.

(D) Mobility.
(E) Self-direction.
(F) Capacity for independent living.
(G) Economic self-sufficiency; and

2. Without 1915 (i) services the beneficiary is at risk of not increasing or maintaining sufficient level of functioning in order to achieve their individual goals of independence, recovery, productivity or community inclusion and participation.

6. ☑ Needs-based Institutional and Waiver Criteria. *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based eligibility criteria	**NF (& NF LOC** waivers)**	**ICF/IID (& ICF/IID LOC waivers)**	**Applicable Hospital* (& Hospital LOC waivers)**
1. Have a substantial functional limitation in 1 or more of the following areas of major life activity: (A) Self-care. (B) Communication. (C) Learning. (D) Mobility. (E) Self-direction. (F) Capacity for independent living. (G) Economic self-sufficiency; AND 2. Without 1915 (i) services the beneficiary is at risk of not increasing or maintaining sufficient level of functioning in order to achieve their individual goals of independence, recovery, productivity, or community inclusion and participation.	Must meet nursing facility level of care, e.g. demonstrate 1) need for assistance with ADLs of bed mobility, transfers, toilet use, or eating, 2) cognitive performance deficits, a) severely impaired in decision making, b) short-term memory problem and at least moderately impaired in decision making, or c) short-term memory problem and is sometimes or rarely understood 3) physician involvement with unstable medical condition within the last 14 days, 4) have at least one treatment or condition in the last 14 days including: stage 3-4 pressure ulcers, intravenous or parenteral feedings, intravenous medications, end-stage care, daily tracheostomy, respiratory, or suctioning care, pneumonia, daily oxygen therapy, daily insulin with 2 order	Must meet ICF/IID level of care, e.g. current assessments of the beneficiary reflect evidence of a developmental disability and/or serious mental illness. The beneficiary's intellectual or functional limitations indicate that he/she would be eligible for health, habilitative, and active treatment services provided at the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care [U.S. PL 111-256.	Must meet long-term acute care hospital (LTACH) level of care, e.g. 1) have a medically complex condition, 2) demonstrate active comorbidities that require complex medical management and a multidisciplinary treatment plan to promote medical and functional improvement lead by a medical practitioner; and 3) have a reasonable potential to benefit from an intense medical treatment program.

	changes, or peritoneal or hemodialysis, 5) received at least 45 minutes of skilled speech, occupational or physical rehabilitation therapies in the last 7 days 6) have displayed challenging behaviors (wandering, verbally abusive, physically abusive, socially inappropriate/disruptive, resisted care in 4 of the last 7 days or had delusions or hallucinations in the last 7 days. 7) be LTSS participant for a year or more and have service dependency 8) be determined medically frail.		

*Long Term Care/Chronic Care Hospital **LOC= level of care

7. ☑ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

Individual beneficiaries' with a serious emotional disturbance, serious mental illness and/or intellectual/developmental disability.

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

(By checking the following box the State assures that):

8. ☑ **Adjustment Authority**. The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. **Reasonable Indication of need for services:** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be

documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services**. The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is*:* (1) One	
ii.	**Frequency of services**. The state requires (select one):	
	☐	**The provision of 1915(i) services at least monthly**
	☑	**Monthly monitoring of the individual when services are furnished on a less than monthly basis** If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency: At least one 1915(i) service every three months in addition to monthly monitoring.

Home and Community-Based Settings

(By checking the following box the State assures that):

1. ☑ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):*

(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

The state assures that this 1915(i) will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings statewide transition plan. The state will implement any CMCS required changes by the end of the transition period as outlined in the home and community-based settings statewide transition plan. Approximately 72% of individuals receiving these state plan services have the services delivered in settings that are following the federal HCBS Settings Rule. These settings include their own home where their names are on the leases and if they have roommates, have chosen those people who live with them; or living with family members in the home of their relative (non-provider owned or controlled), or living with a foster family where only one or two individuals with disabilities share a home with their foster family. In each of these settings, individuals have full access to the home, such as meals and snacks available at any time, ability to have visitors, having privacy for conducting personal business, and can come and go in the community. These settings allow the participants to be in control of their life and be fully integrated in the community. More information can be found on the Statewide Transition Plan. https://www.michigan.gov/mdhhs/0,5885,7-339-71547_2943-334724--,00.html and https://www.michigan.gov/documents/mdhhs/Michigan_STP_623488_7.pdf

The Medicaid Provider Manual has a Chapter on Home and Community Based Services and within that chapter, it establishes the expectation that any new HCBS provider must be in immediate compliance with the rule and it reads as follows:

3.7 NEW PROVIDERS

Effective October 1, 2017, any new HCBS provider and their provider network must be in immediate compliance with the federal HCBS Final Rule in order to render services to Medicaid beneficiaries. This requirement does not apply to existing providers and their provider networks who rendered HCBS to Medicaid beneficiaries before the effective date of this requirement. The Michigan Department of Health and Human Services (MDHHS) will continue to work with existing providers towards coming into compliance with the federal HCBS Final Rule as specified in the State Transition Plan.

In order to comply with the federal HCBS Final Rule, new providers must:

- Ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Enhance independence;
- Enhance independence in making life choices;
- Enable choice regarding services and who provides them; and
- Ensure that the setting is integrated in, and supports full access to, the greater community.

New residential providers must demonstrate that services are delivered within a setting affording the beneficiary sufficient opportunity and choice to engage with the broader community by ensuring that the:

- Setting is selected by the individual from among setting options;
- Individual has a lease or other legally enforceable agreement providing similar protection;
- Individual has privacy in his/her unit, including lockable doors;
- Individual has a choice of roommates (if applicable) and freedom to furnish or decorate the unit;
- Individual controls his/her own schedule, including access to food at any time;
- Individual can have visitors at any time; and
- Setting is physically accessible.

New non-residential providers must demonstrate that services are delivered within a setting affording the beneficiary sufficient opportunity and choice to engage with the broader community by ensuring that the setting:

- *Does not isolate the individual from the broader community; and*
- *Is not institutional in nature or has the characteristics of an institution.*

Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

1. ☑ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☑ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ☑ The person-centered service plan is reviewed and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

4. **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

Must meet one of the following qualifications:

Mental Health Professional:

An individual who is trained and experienced in the area of mental illness or developmental disabilities and who is one of the following: a physician, psychologist, registered professional nurse licensed or otherwise authorized to engage in the practice of nursing under part 172 of the public health code (1978 PA 368, MCL 333.17201 to 333.17242), licensed master's social worker licensed or otherwise authorized to engage in the practice of social work at the master's level under part 185 of the public health code (1978 PA 368, MCL 333.18501 to 333.18518), licensed professional counselor licensed or otherwise authorized to engage in the practice of counseling under part 181 of the public health code (1978 PA 368, MCL 333.18101 to 333.18177), or a marriage and family therapist licensed or otherwise authorized to engage in the practice of marriage and family therapy under part 169 of the public health code (1978 PA 368, MCL 333.16901 to 333.16915). **NOTE:** The approved licensures for disciplines identified as a Mental Health Professional include the full, limited and temporary limited categories.

Qualified Intellectual Disability Professional (QIDP):

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

Qualified Mental Health Professional (QMHP):

Individual with specialized training (including fieldwork and/or internships associated with the academic curriculum where the student works directly with persons receiving mental health services as part of that experience) or one year experience in treating or working with a person who has mental illness; and is a psychologist, physician, educator with a degree in education

from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, behavior analyst, registered nurse, therapeutic recreation specialist, licensed or limited-licensed professional counselor, licensed or limited licensed marriage and family therapist, a licensed physician's assistant or a human services professional with at least a bachelor's degree or higher in a human services field.

5. Responsibility for Development of Person-Centered Service Plan. There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

The Michigan Mental Health Code establishes the right for all individuals to have an Individual Plan of Service (IPOS) developed through a person-centered planning process (Section 712, added 1996). The PIHP shall monitor quality of implementation of person-centered planning by its sub-contracted network of providers in accordance with the MDHHS Person-Centered Planning Practice Guideline (Attachment P 4.4.1.1) and inform the individual/family or authorized representative(s) of their rights to choose among providers for individual case management/supports coordination, or self-direct. If the individual/family or authorized representative(s) prefer an independent facilitator to assist them, the PIHP Customer Services Unit maintains a list of person-centered planning (PCP) independent facilitators [MDHHS/PIHP Contract Attachment P.6.3.1.

The CMHSP or local contracted provider agency chosen by the individual and/or their family, under contract with the PIHP, is responsible for the development and implementation of the Individual Plan of Services (IPOS)

The case manager, supports coordinator or other qualified staff or independent facilitator that assists in developing the IPOS is not a provider of any other service for that individual;

Qualified staff must be able to perform the following functions:

1. Planning and/or facilitating planning using person-centered. This function may be delegated to an independent facilitator chosen by the family or authorized representative(s).

2. Developing an IPOS using the person-centered planning process, including revisions to the IPOS at the request of the beneficiary/guardian or authorized representative(s) or as changing circumstances may warrant.

3. Linking to, coordinating with, follow-up of, and advocacy with all medically necessary supports and services, including the Medicaid Health Plan, Medicaid fee-for-service, or other health care providers.

4. Monitoring of the 1915 i service and other mental health services the individual receives.

5. Brokering of providers of services/supports

6. Assistance with access to entitlements and/or legal representation.

Provider qualifications are as follows:

Supports Coordinator:

1. Chosen by the family or authorized representative(s) of the minor child.

2. Possesses at least a bachelor's degree in human services field and one year of experience with the population the supports coordinator will be serving.

Case Manager:

1. Chosen by the individual/guardian or authorized representative(s) of the minor child.

2. Is a QIDP or QMHP or if the case manager has a bachelor's degree without specialized training or experience, they must be supervised by a QMHP or QIDP.

6. Supporting the Participant in Development of Person-Centered Service Plan. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

A) Each PIHP must have a Customer Services Unit, as required by the MDHHS/PIHP contract in boilerplate language (Section 6.3 and attachment P.6.3.1) to provide the following functions:

- Welcome and orient individuals to services and benefits available, and the provider network.
- Provide information about how to access mental health, primary health, and other community services.
- Provide information about how to access the various rights processes.
- Help individuals with problems and inquiries regarding benefits.
- Assist people with and oversee local complaint and grievance processes.
- Track and report patterns of problem areas for the organization.

The Customer Service Handbook is provided to all new beneficiaries initially and at least annually thereafter. The Handbook contains information explaining the PCP process (Template #8 of the MDHHS/PIHP Contract Attachment P.6.3.1). In addition to the assistance and information provided by the PIHP's Customer Services Unit, the PIHP will provide each family or authorized representative(s) of the minor child a choice of working with a case manager, supports coordinator or other qualified staff, or an independent facilitator to assist them in being actively engaged in the IPOS development process.

The strengths, needs, preferences, abilities, interests, goals, and health status of the beneficiary are determined through pre-planning and the PCP process. Results from the independent assessment and any other medically-necessary assessments by qualified providers, including but not limited to behavioral, psychosocial, speech, occupational and/or physical therapy, social/recreational, and physical and mental health care, are information used in the PCP process. The PCP process considers all life domains of the beneficiary, including emotional, psychological and behavioral health; health and welfare; education/ needs; financial and other resources; cultural and spiritual needs; crisis and safety planning; housing and home; meaningful relationships and attachments; legal issues and planning; daily living; family; social, recreational and community inclusion; and other life domains as identified by the family or authorized representative(s), beneficiary, or assessors.

B) The CMHSP under contract with the PIHP is responsible for the development and implementation of the Individual Plan of Services (IPOS). Each PIHP provider will assist the beneficiary or authorized representative(s) in understanding that they may choose to work with a case manager or supports coordinator or other qualified staff. If the beneficiary, guardian, or authorized representative(s) prefer an independent facilitator to assist them, the PIHP Customer Services Unit maintains a list of person-centered planning (PCP) independent facilitators The IPOS is developed based on findings of all assessments and input from the beneficiary and the family or authorized representative(s). It includes the identification of outcomes based on the beneficiary's stated goals if applicable based on the beneficiary's age, interests, desires and preferences; establishment of meaningful and measurable goals to achieve identified outcomes; determination of the amount, scope, and duration of all medically-necessary services, for those supports and services provided through the public mental health system; identification of other services and supports the beneficiary, family or authorized representative(s) may require to which the public mental

health system will assist with linking to the necessary resources. The IPOS directs the provision of supports and services to be provided to assist the beneficiary in achieving the identified outcomes.

The Person-Centered Planning (PCP) process to develop the Individual Plan of Services (IPOS) is required by the Michigan Mental Health Code (MCL 330.1712). Additionally, for children, the concepts of person-centered planning are incorporated into a family-driven, youth-guided approach that encompasses the belief that the family is at the center of the service planning process and the service providers are collaborators. The PCP process is an individualized, needs-driven, strengths-based process for children and their families or authorized representative(s). Consistent with Michigan's strong focus on a family-driven/youth-guided service planning process, all meetings are scheduled at times and locations convenient to the child and family or authorized representative(s). The family or authorized representative(s) of the minor child identify other people to participate in planning, such as extended family members, friends, neighbors and other health and supports professionals.

The IPOS must specify how identified supports and services will be provided as part of an overall, comprehensive set of supports and services that does not duplicate services that are the responsibility of another entity, such as a private insurance or other funding authority. Per the Michigan Medicaid Provider Manual (MPM), “The PIHP must offer direct assistance to explore and secure all applicable first- and third-party reimbursements and assist the beneficiary to make use of other community resources for non- Medicaid services, or Medicaid services administered by other agencies.”

The IPOS must address the health and welfare of the beneficiary. This may include coordination and oversight of any identified medical care needs to ensure health and safety, such as medication complications, changes in psychotropic medications, medical observation of unmanageable side effects of psychotropic medications or comorbid medical conditions requiring care.

The MPM requires that all services specified in the IPOS must be “[d]delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.”

Life domain planning is always a blend of formal and informal resources, such as natural supports. It uses strategies that are based on strengths, focused on need, are individualized and community based. The IPOS identifies each of the interventions/responsibilities to be implemented, and who is responsible to implement or monitor the service. MDHHS encourages the use of natural supports to assist in meeting the beneficiary’s needs to the extent that the family or authorized representative(s) or friends who provide the natural supports are willing and able to provide this assistance. The use of natural supports must be documented in the beneficiary’s IPOS.

Per the MPM, each beneficiary must be made aware of the amount, duration, and scope of the services to which they are entitled. Therefore, each plan of service must contain the expected date any authorized service is to commence, and the specified amount, scope, and duration of each authorized service within 7 days of the commencement of services, or if an individual is hospitalized for less than 7 days, before discharge or release. The beneficiary must receive a copy of their individual plan of service within 15 business days of completion of the plan.

The IPOS is a dynamic document that is revised based on changing needs, newly-identified or developed strengths and/or the result of periodic reviews and/or assessments. Per the MPM, "[t]he individual plan of service shall be kept current and modified when needed (reflecting changes in the intensity of the beneficiary's health and welfare needs or changes in the beneficiary's preferences for support). A beneficiary or his/her guardian or authorized representative may request and review the plan at any time. A formal review of the plan with the beneficiary and his/her guardian or authorized representative shall occur not less than annually to review progress toward goals and objectives and to assess beneficiary satisfaction. The review may occur during person centered planning."

7. Informed Choice of Providers. *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

Each PIHP must maintain a provider network that enables an individual beneficiary, the family or authorized representative(s) of the minor child to choose from among a range of available network providers and change providers within the PIHP in accordance with the Balanced Budget Act of 1997 and the MDHHS/PIHP contract. Each PIHP must have a Customer Services Unit that will provide the beneficiary, family or authorized representative(s) with information about the choice of 1915(i) providers and service array (Attachment P.6.3.1) initially and annually. Or the beneficiary may choose a self-determination arrangement. (MDHHS/PIHP Contract Attachment P4.7.1) Additional information and changes to the choices of services and providers will be provided by the PIHP Individually based on the changing needs of the beneficiary and/or their family.

8. Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency. *(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):*

The person centered plan must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation. A copy of the IPOS is distributed to the individual and with all the providers responsible for its implementation.

MDHHS will utilize an electronic data platform called the Waiver Support Application (WSA) portal to manage all eligibility determinations for individuals who receive 1915(i) services. PIHP's will upload the independent HCBS assessment information, and service plan information from the person-centered IPOS in the secure portal for MDHHS review and approval. MDHHS staff will compare the person's service plan information to the individual's needs and goals identified in the assessment, assure that all other resources are used before Medicaid and the plan meets State and Federal requirements, before issuing approval.

9. Maintenance of Person-Centered Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

☐	Medicaid agency	☐	Operating agency	☑	Case manager
☑	Other (*specify):*	The PIHP is responsible for assuring that a written or electronic record of the beneficiaries IPOS is maintained for a minimum of seven years, which exceeds requirements of 45 CFR 92.42. Each PIHP determines the location for storing records and makes these records available for the State to review upon request.			

Services

1. **State plan HCBS.** *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: 1. Specialized Medical Equipment & Supplies

Service Definition (Scope)*:*

Specialized Medical Equipment & Supplies include an item or set of items that enable the individual to increase their ability to perform activities of daily living with a greater degree of independence than without them; to perceive, control, or communicate with the environment in which he/she lives. These are items that are not available through other Medicaid coverage or through other insurances. These items must be specified in the individual plan of service. All items must be ordered by a physician on a prescription as defined within the Medicaid Provider Manual. An order is valid for one year from the date it was signed.

Coverage includes:

- Items necessary for independent living (e.g., Lifeline, sensory integration equipment, electronic devices for emergencies/PERS, etc.)
- Communication devices
- Special personal care items that accommodate the person's disability (e.g., reachers, full-spectrum lamp)
- Prostheses necessary to ameliorate negative visual impact of serious facial disfigurements and/or skin conditions
- Ancillary supplies and equipment necessary for proper functioning of equipment and supply items
- Repairs to covered equipment and supplies that are not covered benefits through other insurances

Assessments by an appropriate health care professional, specialized training needed in conjunction with the use of the equipment and warranted upkeep will be considered as part of the cost of the services.

Coverage excludes:

- Furnishings (e.g., furniture, appliances, bedding) and other non-custom items (e.g., wall and floor coverings, decorative items) that are routinely found in a home.
- Items that are considered family recreational choices.
- Educational supplies required to be provided by the school as specified in the child's Individualized Education Plan.

Covered items must meet applicable standards of manufacture, design, and installation. There must be documentation that the best value in warranty coverage was obtained for the item at the time of purchase.

In order to cover repairs of items, there must be documentation in the individual plan of services that the specialized equipment and supplies continues to medically necessary. All applicable warranty and insurance coverages must be sought and denied before paying for repairs. The PIHP must document that the repair is the most cost-effective solution when compared with replacement or purchase of a new item. If the equipment requires repairs due to misuse or abuse, the PIHP must provide evidence of training in the use of the equipment to prevent future incidents.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Physician	Licensed as a Physician in the State of Michigan under section 333.17001 of the public health code Act 368 of 1978	Not applicable	Prescribed by a Licensed Physician within the scope of his or her practice under Michigan law.
Retail or medical supply stores	N/A	N/A	Items purchased must meet the specialized equipment and supplies service definition

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Physician	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to delivery of services and minimally every 2 years thereafter.
Retail or medical supply stores	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	As needed

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	2. Vehicle Modification
Service Definition (Scope)*:*	

Vehicle modifications include adaptations or alterations to an automobile or van that is the individual's primary means of transportation in order to accommodate the special and medical needs of the individual. These adaptations must be specified in the individual plan of service and enable the individual to integrate more fully into the community and to ensure the health, welfare and safety of the individual. All items must be ordered by a physician on a prescription as defined within the Medicaid Provider Manual. An order is valid for one year from the date it was signed.

Coverage includes:

- Adaptations to vehicles

Assessments by an appropriate health care professional, specialized training needed in conjunction with the use of the adaptations and alterations will be considered as part of the cost of the services.

Coverage excludes:

- The purchase or lease of a vehicle;
- Adaptations or improvements to the vehicle that are not of direct medical or remedial benefit to the individual;
- Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modification(s).

Covered items must meet applicable standards of manufacture, design, and installation. There must be documentation that the best value in warranty coverage was obtained for the item at the time of purchase. In order to cover repairs of vehicle modifications, there must be documentation in the individual plan of services that the alterations continue to medically necessary. All applicable warranty and insurance coverages must be sought and denied before paying for repairs. The PIHP must document that the repair is the most cost-effective solution when compared with replacement or purchase of a new item. If the equipment requires repairs due to misuse or abuse, the PIHP must provide evidence of training in the use of the equipment to prevent future incidents.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

☐ Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Physician	Licensed as a Physician in the State of Michigan under	Not applicable	Prescribed by a Licensed Physician within the scope of his or her practice under Michigan law.

	section 333.17001 of the public health code Act 368 of 1978		
Agency or business	N/A	N/A	Must meet the vehicle modification service definition, may be certified or licensed with MI LARA annually.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Physician	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to delivery of services and minimally every 2 years thereafter.
Agency or business	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to the provision of services and every two years thereafter

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: 3. Enhanced Pharmacy

Service Definition (Scope)*:*

Enhanced pharmacy items are physician-ordered, nonprescription "medicine chest" items as specified in the individual's plan of service. There must be documented evidence that the item is not available through Medicaid or other insurances and is the most cost-effective alternative to meet the beneficiary's need.

The following items are covered only for adult beneficiaries living in independent settings (i.e., own home, apartment where deed or lease is signed by the beneficiary):

- Cough, cold, pain, headache, allergy, and/or gastrointestinal distress remedies
- First aid supplies (e.g., band-aids, iodine, rubbing alcohol, cotton swabs, gauze, antiseptic cleansing pads)

The following items are covered for beneficiaries living in independent settings, with family, or in licensed dependent care settings:

- Special oral care products to treat specific oral conditions beyond routine mouth care (e.g., special toothpaste, tooth-brushes, anti-plaque rinses, antiseptic mouthwashes)
- Vitamins and minerals
- Special dietary juices and foods that augment, but do not replace, a regular diet
- Thickening agents for safe swallowing when the beneficiary have a diagnosis of dysphagia and either:
  - A history of aspiration pneumonia, or
  - Documentation that the beneficiary is at risk of insertion of a feeding tube without the thickening agents for safe swallowing.

Coverage excludes:

• Routine cosmetic products (e.g., make-up base, aftershave, mascara, and similar products)
Additional needs-based criteria for receiving the service, if applicable *(specify):*
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*

☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Physician	Licensed as a Physician in the State of Michigan under section 333.17001 of the public health code Act 368 of 1978	Not applicable	Prescribed by a Licensed Physician within the scope of his or her practice under Michigan law.
Retail or medical supply stores	N/A	N/A	Items purchased must meet the enhanced pharmacy service definition

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Physician	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to delivery of services and minimally every 2 years thereafter.
Agency or business	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to the provision of services and every two years thereafter

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	4. Environmental Modifications

Service Definition (Scope)*:*

Physical adaptations to the beneficiary's own home or apartment and/or workplace. There must be documented evidence that the modification is the most cost-effective alternative to meet the beneficiary's need/goal based on the results of a review of all options, including a change in the use of rooms within the home or alternative housing, or in the case of vehicle modification, alternative transportation. All modifications must be prescribed by a physician. Prior to the environmental modification being authorized, PIHP may require that the beneficiary apply to all applicable funding sources (e.g., housing commission grants, MSHDA, and community development block grants), for assistance. It is expected that the case manager/supports coordinator will assist the beneficiary in the pursuit of these resources. Acceptances or denials by these funding sources must be documented in the beneficiary's records. Medicaid is a funding source of last resort.

Coverage includes:

- The installation of ramps and grab-bars.
- Widening of doorways.
- Modification of bathroom facilities.
- Special floor, wall or window covering that will enable the beneficiary more independence or control over his environment, and/or ensure health and safety.
- Installation of specialized electrical and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the beneficiary.
- Assessments by an appropriate health care professional and specialized training needed in conjunction with the use of such environmental modifications.
- Central air conditioning when prescribed by a physician and specified as to how it is essential in the treatment of the beneficiary's illness or condition. This supporting documentation must demonstrate the cost-effectiveness of central air compared to the cost of window units in all rooms that the beneficiary must use.
- Environmental modifications that are required to support proper functioning of medical equipment, such as electrical upgrades, limited to the requirements for safe operation of the specified equipment.
- Adaptations to the work environment limited to those necessary to accommodate the beneficiary's individualized needs.

Coverage excludes:

- Adaptations or improvements to the home that are not of direct medical or remedial benefit to the beneficiary, or do not support the identified goals of community inclusion and participation, independence or productivity.
- Adaptations or improvements to the home that are of general utility or cosmetic value and are considered to be standard housing obligations of the beneficiary. Examples of exclusions include, but are not limited to, carpeting (see exception above), roof repair, sidewalks, driveways, heating, central air conditioning, garages, raised garage doors, storage and organizers, landscaping and general home repairs.
- Cost for construction of a new home or new construction (e.g., additions) in an existing home.
- Environmental modifications costs for improvements exclusively required to meet local building codes.
- Adaptations to the work environment that are the requirements of Section 504 of the Rehabilitation Act, the Americans with Disabilities Act, or are the responsibilities of Michigan Rehabilitation Services.

The PIHP must assure there is a signed contract with the builder for an environmental modification and the homeowner. It is the responsibility of the PIHP to work with the beneficiary and the builder to ensure that the work is completed as outlined in the contract and that issues are resolved among all parties. In the event that the contract is terminated prior to the completion of the work, Medicaid capitation payments may not be used to pay for any additional costs resulting from the termination of the contract.

The existing structure must have the capability to accept and support the proposed changes. The "infrastructure" of the home (e.g., electrical system, plumbing, well/septic, foundation, heating/cooling, smoke detector systems, roof) must follow all local codes. If the home is not code compliant, other funding sources must be secured to bring the home into compliance.

The environmental modification must incorporate reasonable and necessary construction standards and comply with applicable state or local building codes. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values.

Adaptations may be made to rental properties when the landowner agrees to the adaptation in writing. A written agreement between the landowner and the beneficiary must specify any requirements for restoration of the property to its original condition if the occupant moves and must indicate that Medicaid is not obligated for any restoration costs.

If a beneficiary purchases an existing home while receiving Medicaid services, it is the beneficiary's responsibility to assure that the home will meet basic needs, such as having a ground floor bath/bedroom if the beneficiary has mobility limitations. Medicaid funds may be authorized to assist with the adaptations noted above (e.g., ramps, grab bars, widening doorways) for a recently purchased existing home.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

☐ Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Physician	Licensed as a Physician in the State of Michigan under section 333.17001 of the public health code Act 368 of 1978		Prescribed by a physician, working within their scope of practice

Agency or business	MCL 339.601 (1) MCL 339.601.2401(1) MCL 339.601.2403(3)	Licensed builder or licensed contractor	Must meet environmental modification service definition

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Physician	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to delivery of services and every two years thereafter
Agency or business	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1) and LARA	PIHP is responsible prior to the provision of service and LARA is responsible annually thereafter for licensing.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: 5. Family Support and Training

Service Definition (Scope)*:*

Family-focused services provided to family (natural or adoptive parents, spouse, children, siblings, relatives, foster family, in-laws, and other unpaid caregivers) of persons with serious mental illness, serious emotional disturbance or developmental disability for the purpose of assisting the family in relating to and caring for a relative with one of these disabilities. The services target the family members who are caring for and/or living with an individual receiving mental health services. The service is to be used in cases where the beneficiary is hindered or at risk of being hindered in his ability to achieve goals of:

- Performing activities of daily living;
- Perceiving, controlling, or communicating with the environment in which the individual lives; or
- Improving the person's inclusion and participation in the community or productive activity, or opportunities for independent living.

The training and counseling goals, content, frequency and duration of the training must be identified in the beneficiary's individual plan of service, along with the beneficiary's goal(s) that are being facilitated by this service.

Coverage includes:

- Education and training, including instructions about treatment regimens, and use of assistive technology and/or medical equipment needed to safely maintain the person at home as specified in the individual plan of service.

- Counseling and peer support provided by a trained counselor or peer one-on-one or in group for assistance with identifying coping strategies for successfully caring for or living with a person with disabilities.
- Family Psycho-Education (SAMHSA model -- specific information is found in the GUIDE TO FAMILY PSYCHOEDUCATION, Requirements for Certification, Sustainability, and Fidelity) for individuals with serious mental illness and their families. This evidence-based practice includes family educational groups, skills workshops, and joining.
- Parent-to-Parent Support is designed to support parents/family of children with serious emotional disturbance or developmental disabilities as part of the treatment process to be empowered, confident and have skills that will enable them to assist their child to improve in functioning. The trained parent support partner, who has or had a child with special mental health needs, provides education, training, and support and augments the assessment and mental health treatment process. The parent support partner provides these services to the parents and their family. These activities are provided in the home and in the community. The parent support partner is to be provided regular supervision and team consultation by the treating professionals

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

☐ Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Mental Health Professional	Dependent on scope of practice	Dependent on scope of practice	An individual who is trained and experienced in the area of mental illness or developmental disabilities and who is one of the following: a physician, psychologist, registered professional nurse licensed or otherwise authorized to engage in the practice of nursing under part 172 of the public health code (1978 PA 368, MCL 333.17201 to 333.17242), licensed master's social worker licensed or otherwise authorized to engage in the practice of social work at the master's level under part 185 of the public health code (1978 PA 368, MCL 333.18501 to 333.18518), licensed professional counselor licensed or otherwise authorized to engage in the

			practice of counseling under part 181 of the public health code (1978 PA 368, MCL 333.18101 to 333.18177), or a marriage and family therapist licensed or otherwise authorized to engage in the practice of marriage and family therapy under part 169 of the public health code (1978 PA 368, MCL 333.16901 to 333.16915). **NOTE:** The approved licensures for disciplines identified as a Mental Health Professional include the full, limited and temporary limited categories.
Child Mental Health Professional	Dependent on scope of practice	Dependent on scope of practice	Individual with specialized training and one year of experience in the examination, evaluation, and treatment of minors and their families and who is a physician, psychologist, licensed or limited-licensed master's social worker, licensed or limited-licensed professional counselor, or registered nurse; **or** an individual with at least a bachelor's degree in a mental health-related field from an accredited school who is trained and has three years supervised experience in the examination, evaluation, and treatment of minors and their families; or an individual with at least a master's degree in a mental health-related field from an accredited school who is trained and has one year of experience in the examination, evaluation and treatment of minors and their families.
Qualified Mental Health Professional	Dependent on scope of practice	Dependent on scope of practice	Individual with specialized training (including fieldwork and/or internships associated with the academic curriculum where the student works directly with persons receiving mental health services as part of that experience) or one year experience in treating or working with a person who has mental illness; and is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, behavior analyst, registered nurse, therapeutic recreation specialist, licensed or limited-licensed professional counselor, licensed or limited licensed marriage and family therapist, a licensed

			physician's assistant or a human services professional with at least a bachelor's degree or higher in a human services field.
Qualified Intellectual Disability Professional	Dependent on scope of practice	Dependent on scope of practice	Individual with specialized training (including fieldwork and/or internships associated with the academic curriculum where the student works directly with individuals with intellectual or developmental disabilities as part of that experience) or one year experience in treating or working with a person who has intellectual disability; and is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, behavior analyst, registered nurse, registered dietician, therapeutic recreation specialist, a licensed or limited-licensed professional counselor, or a human services professional with at least a bachelor's degree or higher in a human services field.
Parent Support Partner	None	None	Individual who: • has lived experience as a parent/caregiver of a child with Serious Emotional Disturbance and Intellectual/Developmental Disability, and • is employed by the PIHP/CMHSP or its contract providers, and is trained in the Michigan Department of Health and Human Services approved curriculum and ongoing training model.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Mental Health Professional	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to delivery of services and every two years thereafter
Child Mental Health Professional	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to delivery of services and every two years thereafter
Qualified Mental Health Professional	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to delivery of services and every two years thereafter

Qualified Intellectual Disability Professional	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to delivery of services and every two years thereafter
Qualified Behavioral Health Professional	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to delivery of services and every two years thereafter
Parent Support Partner	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to delivery of services and every two years thereafter

Service Delivery Method. *(Check each that applies)*:

☑	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: 6. Fiscal Intermediary

Service Definition (Scope)*:*

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

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

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

Fiscal intermediary services may not be authorized for use by a beneficiary's representative where that representative is not conducting tasks in ways that fit the beneficiary's preferences, and/or do not promote achievement of the goals contained in the beneficiary's plan of service so as to promote independence and inclusive community living for the beneficiary, or when they are acting in a manner that is in conflict with the interests of the beneficiary.

Fiscal intermediary services must be performed by entities with demonstrated competence in managing budgets and performing other functions and responsibilities of a fiscal intermediary. Neither providers of other covered services to the beneficiary, family members, or guardians of the beneficiary may provide fiscal intermediary services to the beneficiary.

Additional needs-based criteria for receiving the service, if applicable *(specify):*
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*
☐ Categorically needy *(specify limits):*
☐ Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Entity/Organization or Fiscal Agent	None	None	Must meet fiscal intermediary service requirements. Entity or individual fiscal agent may not be the provider of other covered services for the individual for whom it is providing fiscal intermediary services.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Entity/Organization or Fiscal Agent	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to delivery of services and every two years thereafter

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	7. Housing Assistance
Service Definition (Scope)*:*	
Housing Assistance enables beneficiaries to secure and/or maintain their own housing as set forth in the beneficiaries' individual plan of service. Services must be provided in the home or a community setting and includes the following components: • Conducting a community integration assessment identifying the beneficiaries preferences related to housing (type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration (including what type of setting works best for the individual, assistance in budgeting for housing/living expenses, assistance in	

obtaining/accessing sources of income necessary for community living, assistance in establishing credit and in understanding and meeting obligations of tenancy).

- Assisting beneficiary with finding and securing housing as needed. This may include arranging for or providing transportation.
- Assisting beneficiary in securing supporting documents/records, completing/submitting applications, securing deposits, and locating furnishings.
- Developing an individualized community integration plan based upon the assessment as part of the overall Person-Centered Plan. Identify and establish short and long-term measurable goal(s) and establish how goals will be achieved and how concerns will be addressed.
- Participating in Person-Centered planning meetings at re-determination and/or revision plan meetings as needed.
- Providing supports and interventions per the Person-Centered Plan (individualized community integration portion).
- Supports to assist the individual in communicating with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager. This includes providing support/intervention for dispute resolution with landlord/property manager.
- Housing assistance will provide supports to preserve the most independent living arrangement and/or assist the individual in locating the most integrated option appropriate to the individual.

Coverage excludes:

- Costs for room and board (i.e. rent, mortgage, motel/hotel stays, security deposit etc.)
- Funding for on-going housing costs (i.e. repairs, utility bills, insurance, taxes, appliances, etc.)

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐ Categorically needy *(specify limits):*

☐ Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Mental Health Professional	Dependent on scope of practice	Dependent on scope of practice	An individual who is trained and experienced in the area of mental illness or developmental disabilities and who is one of the following: a physician, psychologist, registered professional nurse licensed or otherwise authorized

			to engage in the practice of nursing under part 172 of the public health code (1978 PA 368, MCL 333.17201 to 333.17242), licensed master's social worker licensed or otherwise authorized to engage in the practice of social work at the master's level under part 185 of the public health code (1978 PA 368, MCL 333.18501 to 333.18518), licensed professional counselor licensed or otherwise authorized to engage in the practice of counseling under part 181 of the public health code (1978 PA 368, MCL 333.18101 to 333.18177), or a marriage and family therapist licensed or otherwise authorized to engage in the practice of marriage and family therapy under part 169 of the public health code (1978 PA 368, MCL 333.16901 to 333.16915). NOTE: The approved licensures for disciplines identified as a Mental Health Professional include the full, limited and temporary limited categories.
Qualified Mental Health Professional	Dependent on scope of practice	Dependent on scope of practice	Individual with specialized training (including fieldwork and/or internships associated with the academic curriculum where the student works directly with persons receiving mental health services as part of that experience) or one year experience in treating or working with a person who has mental illness; and is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, behavior analyst, registered nurse, therapeutic recreation specialist, licensed or limited-licensed professional counselor, licensed or limited licensed marriage and family therapist, a licensed physician's assistant or a human services professional with at least a bachelor's degree or higher in a human services field.
Qualified Intellectual Disability Professional	Dependent on scope of practice	Dependent on scope of practice	Individual with specialized training (including fieldwork and/or internships associated with the academic curriculum where the student works directly with individuals with intellectual or developmental disabilities as part of that experience) or one year experience in

			treating or working with a person who has intellectual disability; and is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, behavior analyst, registered nurse, registered dietician, therapeutic recreation specialist, a licensed or limited-licensed professional counselor, or a human services professional with at least a bachelor's degree or higher in a human services field.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Mental Health Professional	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to delivery of services and every two years thereafter
Qualified Mental Health Professional	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to delivery of services and every two years thereafter
Qualified Intellectual Disability Professional	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to delivery of services and every two years thereafter

Service Delivery Method. *(Check each that applies)*:

☑	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: 8. Respite Services

Service Definition (Scope)*:*

Respite services are intended to assist in maintaining a goal of living in a natural community home and are provided on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time. In those cases, community living supports, or other services of paid support or training staff, should be used.

Decisions about the methods and amounts of respite should be decided during person-centered planning. PIHPs may not require active clinical treatment as a prerequisite for receiving respite care. These services do not supplant or substitute for community living support or other services of paid support/training staff.

- "Short-term" means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations).

- "Intermittent" means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with a time period in between.
- "Primary" caregivers are typically the same people who provide at least some unpaid supports daily.
- “Unpaid" means that respite may only be provided during those portions of the day when no one is being paid to provide the care, i.e., not a time when the beneficiary is receiving a paid State Plan (e.g., home help) or waiver service (e.g., community living supports) or service through other programs (e.g., school).
- Children who are living in a family foster care home may receive respite services. The only exclusion of receiving respite services in a family foster care home is when the child is receiving Therapeutic Foster Care as a Medicaid SED waiver service because that is considered in the bundled rate. (Refer to the Child Therapeutic Foster Care subsection in the Children’s Serious Emotional Disturbance Home and Community-Based Services Waiver Appendix for additional information.)

Since adult beneficiaries living at home typically receive home help services and hire their family members, respite is not available when the family member is being paid to provide the home help service but may be available at other times throughout the day when the caregiver is not paid.

Respite care may be provided in the following settings:

- Beneficiary’s home or place of residence
- Licensed family foster care home
- Facility approved by the State that is not a private residence, (e.g., group home or licensed respite care facility)
- Home of a friend or relative chosen by the beneficiary and members of the planning team
- Licensed camp
- In community (social/recreational) settings with a respite worker trained, if needed, by the family
- Licensed family child-care home

Respite care may not be provided in:

- Day program settings, ICF/IIDs, nursing homes, or hospitals

Respite care may not be provided by:

- Parent of a minor beneficiary receiving the service
- Spouse of the beneficiary served
- Beneficiary’s guardian
- Unpaid primary care giver

Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence.

The state will demonstrate compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) by January 1, 2020, or January 1, 2021 if Michigan receives approval of a good faith effort exemption request, and for home health services by January 1, 2023 in accordance with section 12006 of the 21st Century CURES Act.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any

individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Direct Support Specialist	None	None	Individual with specialized training, is able to perform basic first aid procedures; trained in the beneficiary's plan of service, as applicable; is at least 18 years of age; able to prevent transmission of communicable disease; able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedures, and to report on activities performed; and in good standing with the law.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Direct Support Specialist	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to delivery of services and every two years thereafter

Service Delivery Method. *(Check each that applies)*:

☑	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	9. Skill Building Assistance
Service Definition (Scope)*:*	

Skill-building assistance consists of activities identified in the individual plan of service that assist a beneficiary to increase their economic self-sufficiency and/or to engage in meaningful activities such as school, work, and/or volunteering. The services occur in community-based integrated settings with individuals without disabilities, provide knowledge and specialized skill development and/or supports to achieve specific outcomes consistent with the individual's identified goals with the purpose of furthering habilitation goals that will lead to greater opportunities of community independence, inclusion, participation, and productivity.

Services includes:

- Assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills
- Work preparatory (time-limited work pathway) services to attain individual competitive integrated employment in the community in which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.
    - Services are intended to develop and teach skills that lead to individual competitive integrated employment including, but not limited to; ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety and mobility training
    - Provide learning and work experiences, including volunteering, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in competitive integrated employment
    - Are expected to occur over a defined period of time with specific employment-related goals and outcomes to be achieved, as determined by the individual's person-centered service plan
    - Enable an individual to attain individual competitive integrated employment and with the job matched to the individual's interests, strengths, priorities, abilities, and capabilities.
    - Participation in skill-building is not a required pre-requisite for individual competitive integrated employment or receiving supported employment services

Skill-building service component(s) needed for each individual are documented, coordinated, and non-duplicative of other services otherwise available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

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

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*

☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Direct Support Professional	None	None	Individual with specialized training, is able to perform basic first aid procedures; trained in the beneficiary's plan of service, as applicable; is at least 18 years of age; able to prevent transmission of communicable disease; able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedures, and to report on activities performed; and in good standing with the law.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Direct Support Professional	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to delivery of services and every two years thereafter

Service Delivery Method. *(Check each that applies)*:

☑	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	10. Community Living Supports

Service Definition (Scope)*:*

Community Living Supports (CLS) are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity. The supports may be provided in the participant's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.).Coverage includes:

Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training in the following activities:

- Meal preparation
- Laundry
- Routine, seasonal, and heavy household care and maintenance

- Activities of daily living (e.g., bathing, eating, dressing, personal hygiene)
- Shopping for food and other necessities of daily living

CLS services may not supplant services otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973 or state plan services, e.g., Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Expanded Home Help (assistance in the individual's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance appears to be needed, the beneficiary must request Home Help and, if necessary, Expanded Home Help from MDHHS. CLS may be used for those activities while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help or Expanded Home Help. If the beneficiary requests it, the PIHP case manager or supports coordinator must assist him/her in requesting Home Help or in filling out and sending a request for Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the MDHHS assessment.

Staff assistance, support and/or training with activities such as:

- Money management
- Non-medical care (not requiring nurse or physician intervention)
- Socialization and relationship building
- Transportation from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence (transportation to and from medical appointments is excluded)
- Participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts and events in a park; volunteering; voting)
- Attendance at medical appointments
- Acquiring or procuring goods, other than those listed under shopping, and non-medical services
- Reminding, observing and/or monitoring of medication administration

CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, state plan coverage Personal Care in Specialized Residential Settings. Transportation to medical appointments is covered by Medicaid through MDHHS or the Medicaid Health Plan. Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses, or parents of minor children), or guardian of the beneficiary receiving community living supports. CLS assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living and/or shopping may be used to complement Home Help or Expanded Home Help services when the individual's needs for this assistance have been officially determined to exceed the DHS's allowable parameters. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a MDHHS decision. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help.

Community Living Supports (CLS) provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For children and adults up to age 26

who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings

The state will demonstrate compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) by January 1, 2020, or January 1, 2021 if Michigan receives approval of a good faith effort exemption request, and for home health services by January 1, 2023 in accordance with section 12006 of the 21st Century CURES Act.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*

☐ Categorically needy *(specify limits):*

☐ Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Direct Support Professional	None	None	Individual is able to perform basic first aid procedures and is trained in the beneficiary's plan of service, as applicable; is at least 18 years of age; able to prevent transmission of communicable disease; able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedures, and to report on activities performed; and in good standing with the law.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Direct Support Professional	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to delivery of services and every two years thereafter

Service Delivery Method. *(Check each that applies)*:			
☑	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	11. Supported/Integrated Employment

Service Definition (Scope)*:*

Supported/Integrated Employment services are services that are provided in a variety of community settings for the purposes of supporting individuals in obtaining and sustaining individual competitive integrated employment. Individual competitive integrated employment refers to full or part-time work at minimum wage or higher, with wages and benefits similar to workers without disabilities performing the same work, and fully integrated with co-workers without disabilities. Supported employment services promote self-direction, are customized, and aimed to meet an individual's personal and career goals and outcomes identified in the individualized person-centered service plan. Services may be provided continuously, intermittently, on behalf of, or on a diminishing basis as needed to promote community inclusion and competitive integrated employment.

Coverage includes:

- Job-related discovery, person-centered employment/career planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits and work-incentives planning and management, asset development and career advancement services career planning that supports an individual to make informed choices about individual competitive integrated employment or self-employment. The outcome of this service is sustained individual competitive integrated employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals as outlined in the individual's person-centered service plan.

Supported employment services include the following categories:

- Individual supported employment supports sustained paid employment at or above the minimum wage and career development in an integrated, competitive setting in the general workforce, in a job that meets personal and career goals
- Self-employment refers to an individual-run business that nets the equivalent of a competitive wage, after reasonable period for start-up, and is either home-based or takes place in regular integrated business, industry or community-based settings
- Small group supported employment support are services and training activities provided in typical business, industry and community settings for groups of two to six workers with disabilities paying at least minimum wage. The purpose of funding for this service is to support sustained paid employment and work experience that leads to individual competitive integrated employment. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities, Supported employment small group employment support must promote integration into the workplace and interaction between workers with disabilities and people without disabilities in those workplaces.

Supported/integrated employment service component(s) needed for each individual are documented, coordinated, and non-duplicative of other services otherwise available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

If an individual has a need for transportation to participate, maintain, or access the skill-building services, the same provider may be reimbursed for providing this transportation, only after it is determined that it is not otherwise available (e.g. volunteer, family member) and is the least expensive available means suitable to the beneficiary's need, in accordance with the Medicaid Provider Manual non-emergency medical transportation policy
Additional needs-based criteria for receiving the service, if applicable *(specify):*
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*

☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Employment Specialist/Job Coach	None	None	Individual has completed specialized training; is able to perform basic first aid procedures, is trained in the beneficiary's plan of service, as applicable; is at least 18 years of age; able to prevent transmission of communicable disease; able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedures, and to report on employment related activities performed; and in good standing with the law.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Employment Specialist/Job Coach	The PIHP is responsible for assuring the provider is credentialed as required by the MDHHS/PIHP Contract (Attachment P.7.1.1)	Prior to delivery of services and every two years thereafter

Service Delivery Method. *(Check each that applies)*:

☑	Participant-directed	☑	Provider managed

8. ☑ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining

to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

The HCBS services that are impacted by the above assurance are Community Living Supports (CLS), Skill Building, Respite, and Supported/Integrated Employment. These services do not allow for payment to relatives or legally responsible individuals/legal guardians as outlined in the descriptions found in the Medicaid provider manual.

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. (S*elect one):*

○	The state does not offer opportunity for participant-direction of State plan HCBS.
☑	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

2. Description of Participant-Direction. (Provide an overview of the opportunities for participant-*direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

Attachment P.4.7.1 of the MDHHS/PIHP contract contains the Self-Determination Policy and Practice Guideline. The guideline sets the standards and expectations for self-directed care. Every beneficiary accessing iSPA services will be informed of self-directed opportunities through their local CMHSP/PIHP on an ongoing basis. Each PIHP entity are involved in supporting participant direction though allocation of resources and education to individuals pursuing self-directed options as outlined in the MDHHS/PIHP contract.

Self-determination is the value that people served by the public mental health system must be supported to have a meaningful life in the community. The components of a meaningful life include work or volunteer activities that are chosen by and meaningful to person, reciprocal relationships with other people in the community, and daily activities that are chosen by the individual and support the individual to connect with others and contribute to his or her community. With arrangements that support self-determination, individuals have control over an individual budget for their mental health services and supports to live the lives they want in the community. The public mental health system must offer arrangements that support self-determination, assuring methods for the person to exert direct control over how, by whom, and to what ends they are served and supported.

Person-centered planning (PCP) is a central element of self-determination. PCP is the crucial medium for expressing and transmitting personal needs, wishes, goals and aspirations. As the PCP process unfolds, the appropriate mix of paid/non-paid services and supports to assist the individual in realizing/achieving these personally defined goals and aspirations are identified.

The principles of self-determination recognize the rights of people supported by the mental health system to have a life with freedom, and to access and direct needed supports that assist in the pursuit of their life, with responsible citizenship. These supports function best when they build upon natural community experiences and opportunities. The person determines and manages needed supports in close association with chosen friends, family, neighbors, and co-workers as a part of an ordinary community life.

Person-centered planning and self-determination underscore a commitment in Michigan to move away from traditional service approaches for people receiving services from the public mental health system. In Michigan, the flexibility provided through the contractual guidance of MDHHS and the Mental Health Code requirements of PCP, have reoriented organizations to respond in new and more meaningful ways. Recognition has increased among providers and professionals that many individuals may not need, want, or benefit from a clinical regimen, especially when imposed without clear choice. Many provider agencies are learning ways to better support the individual to choose, participate in, and accomplish a life with personal meaning. This has meant, for example, reconstitution of segregated programs into non-segregated options that connect better with community life.

Self-determination builds upon the choice already available within the public mental health system. In Michigan, all Medicaid beneficiaries who receive services through the public mental health system have a right under the Balanced Budget Act (BBA) to choose the providers of the services and supports that are identified in their individual plan of service "to the extent possible and appropriate." Qualified providers chosen by the beneficiary, but who are not currently in the network or on the provider panel, should be placed on the provider panel. Within the PIHP, choice of providers must be maintained at the provider level. The individual must be able to choose from at least two providers of each covered support and service and must be able to choose an out-of-network provider under certain circumstances. Provider choice, while critically important, must be distinguished from arrangements that support self-determination. The latter arrangements extend individual choice to his/her control and management over providers (i.e., directly employs or contracts with providers), service delivery, and budget development and implementation.

In addition, to choice of provider, individuals using mental health services and supports have access to a full-range of approaches for receiving those services and supports. Agencies and providers have obligations and underlying values that affirm the principles of choice and control. Yet, they also have long-standing investments in existing programs and services, including their investments in capital and personnel resources. Some program approaches are not amenable to the use of arrangements that support self-determination because the funding and hiring of staff are controlled by the provider (for example, day programs and group homes) and thus, preclude individual employer or budget authority.

It is not anticipated that every person will choose arrangements that support self-determination. Traditional approaches are offered by the system and used very successfully by many people. An arrangement that supports self-determination is one method for moving away from predefined programmatic approaches and professionally managed models. The goals of arrangements that support self-determination, on an individual basis, are to dissolve the isolation of people with disabilities, reduce segregation, promote participation in community life and realize full citizenship rights.

3. Limited Implementation of Participant-Direction. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to state wideness requirements. Select one):*

☑	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the state affected by this option)*:

4. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
1. Specialized Medical Equipment & Supplies	☐	☑
2. Vehicle Modification	☐	☑
3. Community Living Supports	☑	☑
4. Enhanced Pharmacy	☐	☑
5. Environmental Modifications	☐	☑
6. Family Support and Training	☑	☑
7. Fiscal Intermediary	☐	☑
8. Housing Assistance	☑	☑
9. Respite Care Services	☑	☑
10. Skill Building Assistance	☑	☑
11. Supported/Integrated Employment Services	☑	☑

5. Financial Management. (*Select one)* :

☑	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☑ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State plan HCBS that the individual will be responsible for directing;
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

7. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

Attachment P.4.7.1 of the MDHHS/PIHP contract contains the Self-Determination Policy and Practice Guideline. The guideline sets the standards and expectations for self-directed care. Termination of participation is addressed as part of that policy.

The most effective method for making changes is through the person-centered/family-driven/youth-guided planning process in order to identify and address problems that may be interfering with the success of the arrangement.

Either party—the PIHP or the person—may terminate a self-determination agreement, and therefore, the self-determination arrangement. Common reasons that a PIHP may terminate an agreement after providing support and other interventions described in this guideline include: failure to comply with Medicaid documentation requirements; failure to stay within the authorized funding in the individual budget; inability to hire and retain qualified providers; substantiated fraud or abuse of Medicaid funding by the individual and/or family; and conflict between the individual and providers that results in an inability to implement IPOS. Prior to the PIHP terminating an agreement, and unless it is not feasible, the PIHP shall inform the individual of the issues that have led to consideration of a discontinuation or alteration decision, in writing, and provide an opportunity for problem resolution. Typically, resolution will be conducted using the person-centered planning process, with termination being the option of choice if other mutually-agreeable solutions cannot be found. In any instance of PIHP discontinuation or alteration of a self-determination arrangement, the local processes for dispute resolution may be used to address and resolve the issues.

- Termination of a Self-Determination Agreement by a PIHP is not a Medicaid Fair Hearings Issue. Only a change, reduction, or termination of Medicaid services can be appealed through the Medicaid Fair Hearings Process, not the use of arrangements that support self-determination to obtain those services.
- Discontinuation of a self-determination agreement, by itself, shall neither change the individual's IPOS, nor eliminate the obligation of the PIHP to assure specialty mental health services and supports required in the IPOS are provided.
- In any instance of PIHP discontinuation or alteration, the person must be provided an explanation of applicable appeal, grievance and dispute resolution processes and (when required) appropriate notice.
- All self-directed services and supports are continuity ensured during the appeal, grievance, and dispute resolution process, and individuals health and welfare is assured during the transition process for voluntary and involuntary termination of participant direction in accordance with the MDHHS/PIHP contract.

8. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can select, manage, and dismiss State plan HCBS providers). (*Select one):*

○	The state does not offer opportunity for participant-employer authority.	
☑	Participants may elect participant-employer Authority *(Check each that applies):*	
	☑	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☑	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget that does not result in payment for medical assistance to the individual). (*Select one):*

○	The state does not offer opportunity for participants to direct a budget.
☑	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*
	An individual budget includes the expected or estimated costs of a concrete approach of obtaining the mental health services and supports included in the plan of service. Both the individual plan of service (IPOS) and the individual budget are developed in conjunction with one another through the person-centered planning process (PCP). Both the participant and the PIHP must agree to the amounts in the individual budget before it is authorized for use by the participant. This agreement is based not only on the amount, scope and duration of the services and supports in the IPOS, but also on the type of arrangements that the participant is using to obtain the services and supports. Those arrangements are also determined primarily through the PCP process. Michigan uses a retrospective zero-based method for developing an individual budget. The amount of the individual budget is determined by costing out the services and supports in the IPOS, after an IPOS that meets the participant's needs and goals has been developed. In the IPOS, each service or support is identified in amount, scope and duration (such as hours per week or month). The individual budget should be developed for a reasonable period of time that allows the participant to exercise flexibility (usually one year). Once the IPOS is developed, the amount of funding needed to obtain the identified services and supports is determined collectively by the participant, the mental health agency (PIHP or designee), and others participating in the PCP process. This process involves costing out the services and supports using the rates for providers chosen by the participant and the number of hours authorized in the IPOS. The rate for directly employed workers must include Medicare and Social Security Taxes (FICA), Unemployment Insurance, and Worker's Compensation Insurance. The individual budget is authorized in the amount of that total cost of all services and supports in the IPOS. The individual budget must include the fiscal intermediary fee if a fiscal intermediary is utilized. Participants must use a fiscal intermediary if they are directly employing workers and/or directly contracting with other providers that do not have contracts with the PIHPs. If a participant chooses to contract only with providers that are already under contract with the PIHP, there is no requirements that a fiscal intermediary be used. Fiscal intermediary is available to any participant using a self-determination arrangement. Each PIHP develops a contract with the fiscal intermediary to provide financial management services (FMS) and sets the rate and costs for the services. The average monthly fee has ranged from $75.00 to $125.00. Actual costs for the FMS will vary depending on the individual's needs and usage of FMS, as well as the negotiated rate between the PIHP and fiscal intermediary.
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*

	Participants must use a fiscal intermediary if they are directly employing workers and/or directly contracting with other providers that do not have contracts with the PIHPs. Most participants use FMS through a fiscal intermediary even if they only contract with providers already under contract with the PIHP; however, there is no requirement that they do so. The funds in an individual budget are transferred to the fiscal intermediary, which handles payment for services and supports in the IPOS upon receipt of invoices and timesheets authorized by the participant. The fiscal intermediary provides both the participant and the mental health agency (PIHP or designee) a monthly report of expenditures and flags expenditures that are over or under the expected amount by ten percent or more. This report is the central mechanism for monitoring implementation of the budget. Over- or underutilization identified in the report can be addressed by the supports coordinator (or another chosen qualified provider) and participant informally or through the PCP process. The supports coordinator supports coordinator assistant, or independent supports broker (or other chosen qualified provider) is responsible for assisting the participant in implementing the individual budget and arrangements, including understanding the budget report. A participant can use an independent supports broker to assist him or her in implementing and monitoring the IPOS and budget. When a participant uses an independent supports broker, the supports coordinator (other qualified provider selected by the participant) has a more limited role in planning and implementation of arrangements so that the assistance provided is not duplicated. However, the authorization and monitoring the IPOS and individual budget cannot be delegated to an Independent Supports Broker by the PIHP or designee. If using FMS through a fiscal intermediary, the supports coordinator, supports coordinator assistant, or independent supports broker (or other chosen qualified provider) receives a copy of the budget and a copy of the monthly budget report. In the required monitoring and face-to-face contact, they have with the participant, the supports coordinator, supports coordinator assistant or independent supports broker (or other qualified provider) must address any over- or under-utilization of the budget that they identify in the monthly budget report. If the participant does not use a fiscal intermediary because he or she only contracts with providers already under contract with the PIHP, the PIHP must provide a monthly budget report to the participant and supports coordinator, supports coordinator assistant or independent supports broker (or other qualified provider) so the participant can effectively manage his or her budget and thereby, exercise budget authority.

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. **Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c document choice of services and providers.**
2. **Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.**
3. **Providers meet required qualifications.**
4. **Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).**
5. **The SMA retains authority and responsibility for program operations and oversight.**
6. **The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**
7. **The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.**

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Requirement	***Service plans a) address assessed needs of 1915(i) participants;*** *b) are updated annually; and c) document choice of services and providers.*
Discovery	
Discovery Evidence *(Performance Measure)*	A) Number and percent of enrolled participants whose IPOS had adequate strategies to address their assessed health and safety risks. N: Number of enrolled cases reviewed whose IPOS had adequate strategies to address their identified health and safety risks assessed D: Number of all enrolled participants sampled
Discovery Activity *(Source of Data & sample size)*	Source: Site Review Aggregate data from the sample by MDHHS across 2 fiscal years Sample Size: stratified random sample for statistically significant number based on total number served by the 1915(i) State plan.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS/BHDDA

Frequency	Ongoing for data collection Each PIHP receives a comprehensive on-site review biennially.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	PIHPs are responsible for remediating any identified issues within 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA. PIHP receives a follow-up review for remediation of identified issues 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA.
Frequency *(of Analysis and Aggregation)*	Annually
Discovery	
Discovery Evidence *(Performance Measure)*	A) Number and percent of Individual Plans Of Services (IPOS) reviewed that address the assessed needs of a beneficiary N: Number of records reviewed with evidence that the IPOS addresses the assessed needs of the beneficiary D: Number of IPOS records reviewed in the sample
Discovery Activity *(Source of Data & sample size)*	Source: Site Review Aggregate data from the sample by MDHHS across 2 fiscal years Sample Size: stratified random sample for statistically significant number based on total number served by the 1915(i) State plan
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS/BHDDA
Frequency	Ongoing for data collection Each PIHP receives a comprehensive on-site review biennially.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation*	PIHPs are responsible for remediating any identified issues within 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA. PIHP receives a follow-up review for remediation of identified issues 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA.

	activities; required timeframes for remediation)	
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement		***Service plans** a) address assessed needs of 1915(i) participants; **b) are updated annually**; and c) document choice of services and providers.*
Discovery		
	Discovery Evidence *(Performance Measure)*	B) Number and percent of reviewed IPOS that were updated within 365 days of their last plan of service N: Number of records reviewed that the IPOS was updated within 365 days D: Number of IPOS records reviewed in the sample
	Discovery Activity *(Source of Data & sample size)*	Source: Site Review Aggregate data from the sample by MDHHS across 2 fiscal years Sample Size: stratified random sample for statistically significant number based on total number served by the 1915(i) State plan
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS/BHDDA
	Frequency	Ongoing for data collection Each PIHP receives a comprehensive on-site review biennially.
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	PIHPs are responsible for remediating any identified issues within 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA. PIHP receives a follow-up review for remediation of identified issues 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA.

Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***Service plans*** *a) address assessed needs of 1915(i) participants; b) are updated annually; and* ***c) document choice of services and providers.***
Discovery	
Discovery Evidence *(Performance Measure)*	C) Number and percent of records reviewed with documented evidence that beneficiaries were informed of their right to choose among providers. N: Number of beneficiaries reviewed who are informed of their right to choose among providers. D: Number of records reviewed in the sample
Discovery Activity *(Source of Data & sample size)*	Source: Site Review Aggregate data from the sample by MDHHS across 2 fiscal years Sample Size: stratified random sample for statistically significant number based on total number served by the 1915(i) State plan
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS/BHDDA
Frequency	Ongoing for data collection Each PIHP receives a comprehensive on-site review biennially.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	PIHPs are responsible for remediating any identified issues within 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA. PIHP receives a follow-up review for remediation of identified issues 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA.
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***Service plans*** *a) address assessed needs of 1915(i) participants; b) are updated annually; and* ***c) document choice of services and providers.***

Discovery	
Discovery Evidence *(Performance Measure)*	C) Number and percent of records reviewed with documented evidence that beneficiaries were informed of their right to choose among services. N: Number of beneficiaries reviewed who are informed of their right to choose among services. D: Number of records reviewed in the sample
Discovery Activity *(Source of Data & sample size)*	Source: Site Review Aggregate data from the sample by MDHHS across 2 fiscal years Sample Size: stratified random sample for statistically significant number based on total number served by the 1915(i) State plan
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS/BHDDA
Frequency	Ongoing for data collection Each PIHP receives a comprehensive on-site review biennially.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	PIHPs are responsible for remediating any identified issues within 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA. PIHP receives a follow-up review for remediation of identified issues 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA.
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future;*** *(b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.*

Discovery		
	Discovery Evidence *(Performance Measure)*	A) Number and percent of evaluations completed where applicants meet the eligibility criteria for 1915(i) State plan HCBS benefit. N: Number of evaluations completed where applicants meet the eligibility criteria for the 1915(i) state plan benefit D: Number of evaluations completed for all applicants
	Discovery Activity *(Source of Data & sample size)*	Source: WSA Sample Size: 100%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS/BHDDA
	Frequency	Ongoing for data collection
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDHHS/BHDDA. The WSA is used to communicate electronically with the PIHPs regarding questions or issues on individual eligibility evaluation that arise as the result of review. The PIHP must respond within 15 days by providing the required additional information. Their response is reviewed to determine that appropriate action was taken and if any additional follow-up is necessary. A less formal, but documented, method of communication is through email exchange. This method is used when MDHHS staff is requesting clarification of a minor point. Responses to emails are expected within 1-2 business days
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***Eligibility Requirements:*** *(a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future;* ***(b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately;*** *and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.*
Discovery	

Discovery Evidence *(Performance Measure)*	B) The number and percent of records reviewed with evidence the instruments and tools were appropriately applied to determine eligibility of 1915(i) services N: Number of cases with evidence that instruments were applied appropriately as part of the eligibility process D: All records reviewed in the sample
Discovery Activity *(Source of Data & sample size)*	Source: WSA Sample Size: 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS/BHDDA
Frequency	Ongoing for data collection
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDHHS/BHDDA The WSA is used to communicate electronically with the PIHPs regarding questions or issues on individual eligibility evaluation that arise as the result of review. The PIHP must respond within 15 days by providing the required additional information. Their response is reviewed to determine that appropriate action was taken and if any additional follow-up is necessary. A less formal, but documented, method of communication is through email exchange. This method is used when MDHHS staff is requesting clarification of a minor point. Responses to emails are expected within 1-2 business days
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***Eligibility Requirements:*** *(a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and* ***(c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.***
Discovery	
Discovery Evidence	C) Number and percent of re-evaluations for eligibility were within 365 days of the last eligibility determination

(Performance Measure)	N: Number of enrolled beneficiaries that were re-evaluated for eligibility within 365 days of their last eligibility determination D: All re-evaluations provided for enrolled beneficiaries for 1915(i) state plan services
Discovery Activity *(Source of Data & sample size)*	Source: WSA Sample Size: 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS/BHDDA
Frequency	Ongoing for data collection
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDHHS/BHDDA The WSA is used to communicate electronically with the PIHPs regarding questions or issues on individual eligibility re-evaluation that arise as the result of review. The PIHP must respond within 15 days by providing the required additional information. Their response is reviewed to determine that appropriate action was taken and if any additional follow-up is necessary. A less formal, but documented, method of communication is through email exchange. This method is used when MDHHS staff is requesting clarification of a minor point. Responses to emails are expected within 1-2 business days.
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***Providers meet required qualifications.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number of licensed providers of state plan services for beneficiaries meet credentialing standards N: Number of providers of state plan services that meet credentialing standards D: All providers reviewed in the sample
Discovery Activity	Source: Site Review Aggregate data from the sample by MDHHS across 2 fiscal years

(Source of Data & sample size)	Sample Size: stratified random sample for statistically significant number based on total number served by the 1915(i) State plan
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS/BHDDA
Frequency	Ongoing for data collection Each PIHP receives a comprehensive on-site review biennially.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	PIHPs are responsible for remediating any identified issues within 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA. PIHP receives a follow-up review for remediation of identified issues 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA.
Frequency *(of Analysis and Aggregation)*	Annually
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of non-licensed, non-certified service providers that meet credentialing standards as stated in the Michigan Medicaid Provider Manual. N: Number of non-licensed, non-certified providers that meet credentialing standards D: All non-licensed, non-certified providers reviewed in the sample
Discovery Activity *(Source of Data & sample size)*	Source: Site Review Aggregate data from the sample by MDHHS across 2 fiscal years Sample Size: stratified random sample for statistically significant number based on total number served by the 1915 (I)SPA
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS/BHDDA
Frequency	Ongoing for data collection Each PIHP receives a comprehensive on-site review biennially.
Remediation	

Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	PIHPs are responsible for remediating any identified issues within 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA. PIHP receives a follow-up review for remediation of identified issues 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA.
Frequency *(of Analysis and Aggregation)*	Annually
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of case records with providers that meet staff training requirements. N: Number of case records with service providers that meet staff training requirements. D: Number of all cases reviewed in the sample.
Discovery Activity *(Source of Data & sample size)*	Source: Site Review Aggregate data from the sample by MDHHS across 2 fiscal years Sample Size: stratified random sample for statistically significant number based on total number served by the 1915 (I)SPA
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS/BHDDA
Frequency	Ongoing for data collection Each PIHP receives a comprehensive on-site review biennially.
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	PIHPs are responsible for remediating any identified issues within 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA. PIHP receives a follow-up review for remediation of identified issues 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA.
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of service settings that meet the home and community based setting requirements N: Number of service settings that meet the home and community based setting requirement D: All service settings in surveys
Discovery Activity *(Source of Data & sample size)*	Source: WSA HCBS Survey Data Sample Size: 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS/BHDDA
Frequency	Continuous and ongoing data collection
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	PIHPs Providers are required to submit a corrective action plan to the PIHPs within 30 days. Providers are responsible for remediating any identified issues within 90 days after the Plan of Correction has been approved by the PIHP.
Frequency *(of Analysis and Aggregation)*	Ongoing

Requirement	***The SMA retains authority and responsibility for program operations and oversight.***
Discovery	
Discovery Evidence	Number and percent of administrative hearing timeframes that were met related to 1915(i) N: Number of administrative hearing timeframes met D: All hearings.

(Performance Measure)	
Discovery Activity *(Source of Data & sample size)*	Source: Appeals database Sample Size: 100% Method: Report compilation and analysis of all beneficiary completed Administrative Law Judge hearings
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS/BHDDA
Frequency	Continuous and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	PIHPs are responsible for remediating any identified issues required by the Decision and Order of the Administrative Law Judge within the timeframe ordered.
Frequency *(of Analysis and Aggregation)*	Annually
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of case records with services that require prior authorization are implemented by the PIHP according to established policy. N: Number of case records that have prior authorization implemented by the PIHP's according to policy D: Number of all case records with services that require prior authorization reviewed in the sample.
Discovery Activity *(Source of Data & sample size)*	Source: Site Review Aggregate data from the sample by MDHHS across 2 fiscal years Sample Size: stratified random sample for statistically significant number based on total number served by the 1915(i) SPA.
Monitoring Responsibilities *(Agency or entity that*	MDHHS/BHDDA

	conducts discovery activities)	
	Frequency	Ongoing for data collection Each PIHP receives a comprehensive on-site review biennially.
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Providers are required to submit a corrective action plan to the PIHPs within 30 days. Providers are responsible for remediating any identified issues within 90 days after the Plan of Correction has been approved by the PIHPIHPs are responsible for remediating any identified issues required by the Decision and Order of the Administrative Law Judge within the timeframe ordered.
	Frequency *(of Analysis and Aggregation)*	Annually
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of IPOS compliance issues that were remediated within 90 days. N: Number cases reviewed with IPOS compliance issues remediated within 90 days. D: All cases reviewed that require remediation of IPOS compliance issues
	Discovery Activity *(Source of Data & sample size)*	Source: Site Review Aggregate data from the sample by MDHHS across 2 fiscal years Sample Size: All cases reviewed that require remediation of IPOS compliance issues
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS/BHDDA
	Frequency	Ongoing for data collection Each PIHP receives a comprehensive on-site review biennially.
Remediation		
	Remediation Responsibilities	PIHPs are responsible for remediating any identified issues within 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA.

	(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	PIHP receives a follow-up review for remediation of identified issues 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA.
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement		***The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers***
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of capitation payments to PIHPs are made in accordance with CMS approved actuarially sound rate methodology. N: Number of capitation payments made to PIHPs at the approved rate through the CMS certified MMIS. D: All capitation payments made to PIHPs through the CMS certified MMIS for participants sampled.
	Discovery Activity *(Source of Data & sample size)*	Source: CHAMPS Aggregate data from the sample by MDHHS across 2 fiscal years Sample Size: stratified random sample for statistically significant number based on total number served by the 1915 (i)SPA
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS/BHDDA
	Frequency	Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required*	PIHPs are responsible for remediating any identified payments issues within 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA. PIHP receives a follow-up review for remediation of identified issues 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA. MDHHS/BHDDA will recoup any inappropriate payments made to PIHPs in accordance with managed care requirements for financial accountability.

	timeframes for remediation)	
	Frequency *(of Analysis and Aggregation)*	Ongoing

Requirement		***The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints***
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of substantiated reports of abuse, neglect, and exploitation that has been remediated. N: Number and percent of substantiated reports of abuse, neglect, and exploitation that has been remediated. D: Number and percent of substantiated reports of abuse, neglect, and exploitation.
	Discovery Activity *(Source of Data & sample size)*	Source: Office of Recipient Rights Sample Size: 100%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS/BHDDA
	Frequency	Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	On a semi-annual basis, local CMHSP ORRs report to MDHHS the summaries of all allegations received and investigated, whether there was an intervention, and the numbers of allegations substantiated. The summaries are reported by category of rights violations. Information from these reports is entered into a database to produce a State report by waiver programs. Follow-up actions by MDHHS include data confirmation, consultation, and on-site follow-up. If there are issues involving potential or substantiated Rights violations, or serious problems with the local Rights office, the state Office of Recipient Rights, which has authority under Section 330.1754(6)(e), may intervene as necessary. The CMHSP level data is aggregated to the PIHP level where affiliations exist. Each CMHSP rights office must include in its semi- annual and annual complaint data reports to the MDHHS Office of Recipient Rights, allegations of all recipient rights complaints investigated or intervened upon on behalf of recipients based upon specific population. An annual report is produced by the State ORR and submitted to stakeholders and the Legislature. Aggregate data are shared with MDHHS-BHDDA, the Quality Improvement Council (QIC) and waiver staff. Information is used by MDHHS to take contract action as needed or by the QIC to make recommendations for system improvements.

Frequency *(of Analysis and Aggregation)*	Annually
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of enrollees requiring emergency medical treatment due to medication error. N: Number of enrollees requiring emergency medical treatment due to medication error. D: All enrollees with reported incidents of emergency medical treatment for injuries or medication errors
Discovery Activity *(Source of Data & sample size)*	Source: The Critical Incident Reporting System (CIRS) provides individual level data on medication errors that resulted in emergency medical treatment or hospitalization. The CIRS is the source for information related to medication errors that are critical incidents. PIHPs will still be required to identify those incidents and carry out actions to prevent or reduce the likelihood that this type of critical incident would re-occur. Sample Size: 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS/BHDDA
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDHHS will monitor the critical incidents related to medication errors through the CIRS to monitor for trends and outliers. MDHHS may require the PIHP to receive additional technical assistance or training as a result of CIRS data. On-site follow-up on reported critical incidents regarding medication errors takes place at a maximum during QMP biennial site reviews. During these site reviews, MDHHS-BHDDA staff verifies the PIHP's process for Critical Incident Reporting is being implemented per MDHHS policy. Any noted shortcomings in the PIHP's processes or outcomes would be reflected in a written site review report which would in turn require submission of a corrective action plan by the PIHP and additional follow-up by MDHHS 90 days after the corrective action plan has been approved.
Frequency *(of Analysis and Aggregation)*	Annually
Discovery	
Discovery Evidence	Number and percent of records being reviewed where the Behavior Treatment Plan Review Committees (BTPRC) policy was followed. N: Number of records being reviewed where the BTPRC policy was followed.

	(Performance Measure)	D: Number of records reviewed with Behavioral Treatment Plan in the sample.
	Discovery Activity *(Source of Data & sample size)*	Source: Site Review Sample Size: Stratified random sample for statistically significant number based on total number served by the 1915 (I)SPA.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS/BHDDA
	Frequency	Ongoing for data collection Each PIHP receives a comprehensive on-site review biennially.
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	PIHPs are responsible for remediating any identified issues within 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA. PIHP receives a follow-up review for remediation of identified issues 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA. MDHHS requires that any individual receiving public mental health services has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as required by the 1997 federal Balanced Budget Act at 42 CFR 438.100 and Sections 740 and 742 of the Michigan Mental Health Code. Michigan's Mental Health Code prohibits the use of restraint or seclusion in any service site except a hospital, center or child caring institutions. (MCL 330.1740, MCL 330.1742) The Michigan Medicaid Manual prohibits placement of a waiver beneficiary into a child caring institution. The Michigan Mental Health Code defines restraint as the use of a physical device to restrict an individual's movement but does not include an anatomical support or protective device. (MCL 330.1700[i]). It defines seclusion as the temporary placement of a recipient in a room alone where egress is prevented by any means. (MCL 330.1700[j]). In addition, the use of restraint and seclusion is addressed in the MDHHS Standards for Behavior Treatment Plan Review Committees, Attachment P.1.4.1 to the Medicaid Specialty Supports and Services Program contract between MDHHS-BHDDA and the PIHPs; the Agreement Between MDHHS-BHDDA and CMHSPs For Managed Mental Health Supports and Services Attachment C.6.8.3.1.d. Each rights office established by the Mental Health Code, including those of the CMHSPs, would be responsible for investigation into apparent or suspected unlawful use of restraint or seclusion in its directly operated or contracted mental health service sites. Unlawful use of restraint or seclusion may also come to the attention of the Rights Office during its Mental Health Code mandated visits to all service sites. Frequency of the site visits is that which is necessary for protection of rights but in no case less than annually. The Department of Licensing and Regulatory Affairs (LARA) is responsible for investigation of reports of unlawful restraint and/or seclusion in a licensed foster care facility. Unlawful use of restraint or seclusion may also

		come to the attention of LARA during announced or unannounced inspections and at the time of the biennial licensure process. Mechanical or chemical restraint and seclusion are prohibited in licensed adult foster care homes per DHS Administrative Rule 400.14308 as follows: R 400.14308 Resident behavior interventions prohibitions. (2) A licensee, direct care staff, the administrator, members of the household, volunteers who are under the direction of the licensee, employees, or any person who lives in the home shall not do any of the following: (a) Use any form of punishment. (b) Use any form of physical force other than physical restraint as defined in these rules. Physical restraint is defined as bodily holding of a resident with no more force than is necessary to limit the resident's movement. (c) Restrain a resident's movement by binding or tying or through the use of medication, paraphernalia, contraptions, material, or equipment for the purpose of immobilizing a resident. (d) Confine a resident in an area, such as a room, where egress is prevented, in a closet, or in a bed, box, or chair or restrict a resident in a similar manner. Monitoring to assure that PIHPs/CMHSPs are not using restraints or seclusion is done by the MDHHS-BHDDA Site Review Team, which reviews agency policy for consistency with State law during biennial visits. The Site Review Team would also watch for any unauthorized use of restraints or seclusion during its review of incident reports and interviews with participants or staff.
	Frequency *(of Analysis and Aggregation)*	Annually
Discovery		
Discovery Evidence *(Performance Measure)*		Number and percent of beneficiaries who have received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents. N: Number of beneficiaries who received information and education in the prior year. D: Number of beneficiaries case records sampled
Discovery Activity *(Source of Data & sample size)*		Source: Site Review Aggregate data from the sample by MDHHS across 2 fiscal years Sample Size: stratified random sample for statistically significant number based on total number served by the 1915 (I)SPA.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*		MDHHS/BHDDA
Frequency		Ongoing for data collection Each PIHP receives a comprehensive on-site review biennially.
Remediation		

Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	PIHPs are responsible for remediating any identified issues within 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA. PIHP receives a follow-up review for remediation of identified issues 90 days after the approved Plan of Correction has been issued by MDHHS/BHDDA.
Frequency *(of Analysis and Aggregation)*	Annually
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of beneficiaries requiring hospitalization due to injury related to the use of physical management (PM) where remediation was complete to avoid future incidents of this type. N: Number of beneficiaries requiring hospitalization due to injury related to the use of PM where remediation was complete to avoid future incidents of this type D: All beneficiaries requiring hospitalization due to injury related to the use of physical management.
Discovery Activity *(Source of Data & sample size)*	Source: The Critical Incident Reporting System (CIRS) provides individual level data on medication errors that resulted in emergency medical treatment or hospitalization. The CIRS is the source for information related to medication errors that are critical incidents. PIHPs will still be required to identify those incidents and carry out actions to prevent or reduce the likelihood that this type of critical incident would re-occur. Sample Size: 100%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS/BHDDA
Frequency	Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation*	Any critical incident for a participant has a short-term response to assure the immediate health and welfare of the participant for whom the incident was reported and a longer- term response to address a plan of action or intervention to prevent further occurrence if applicable. If the incident involves potential criminal activity, the incident would also be reported to law enforcement. If the incident involves an action that may be under the authority of Child Protective Services or Adult Protective Services, the appropriate agency would be notified.

activities; required timeframes for remediation)	Second, the CMHSP would begin the process of determining whether the incident meets the criteria and definition for sentinel events and if they are related to practice of care. If the incident was also reported to the CMHSP ORR, that office begins the process of determining whether there may have been a violation of the participant's rights. If the CMHSP determines the incident is a sentinel event, a thorough and credible root cause analysis is completed, improvements are implemented to reduce risk, and the effectiveness of those improvements must be monitored. Following completion of a root cause analysis or investigation, a CMHSP must develop and implement either a) a plan of action (JCAHO) or intervention (per CMS approval and MDHHS contractual requirement) to prevent further occurrence of the sentinel event; or b) presentation of a rationale for not pursuing an intervention. A plan of action or intervention must identify who will implement and when and how implementation will be monitored or evaluated. The CMHSP ORR also follows its process to investigate and recommend remedial action to the CMHSP Director for follow-up. If an egregious event is reported through the Event Notification or through other sources, MDHHS may follow-up through a number of different approaches, including sending a site reviewer or other clinical professional as appropriate to follow-up immediately, telephone contact, requiring follow-up action by the PIHP, requiring additional training for PIHP providers, or other strategies as appropriate. During a QMP on-site visit, if the site review team member identifies an issue that places a participant in imminent risk to health or welfare, the site review team would invoke an immediate review and response by the PIHP, which must be completed in five to seven business days.
Frequency *(of Analysis and Aggregation)*	Annually

System Improvement

(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

The MDHHS system improvement strategy encompasses 1915(i) SPA with the following three 1915(c)'s waivers: MI Children's Waiver Program, MI Habilitation Supports Waiver, and MI Waiver for Children with Serious Emotional Disturbances.

MDHHS designed the consolidated quality improvement strategy to assess and improve the quality of services and supports provided through the available the 1915(i) services waiver options and the 1915(i) state plan. This is evident in the following components;

a) participant services-all waivers and the 1915(i) offer similar services to participants to remain in the community with the focus on the provision of services and supports to maintain or increase a level of functioning in order to achieve an individual's goals of community inclusion and participation, independence, recovery, or productivity.
b) participant safeguards-all waivers and the 1915(i) follow the same participant safeguards outlined throughout the individual waiver and (i) SPA applications.
c) quality management: the information below outlines the approach which is the same or similar across waivers and the 1915(i).

The quality management approach is the same or similar across waivers and the 1915(i):

a) methodology for discovering information: the state draws from several tools to gather data and measure individual and system performance. Tools utilized include the record review

protocol, the CHAMPS, WSA, HCBS survey, and a Critical Incident Reporting system (CIRS) across all waivers and 1915(i) participants.

b) manner in which individual issues are remedied: MDHHS is the Single State Agency responsible for establishing the components of the quality improvement strategy which includes the remediation of all waiver and 1915 (i) issues at an individual level and all actions and timelines are recorded and tracked through annual monitoring activities.

c) process for identifying and analyzing trends/patterns: Data gathered from the record reviews will be used initially to foster improvements and provide technical assistance at the agency whose records are being reviewed. Annually, this data will be compiled to look for systemic trends and areas in need of improvement and published in the state's annual report. Using encounter data, measure penetration rates of beneficiaries who access services at the PIHP level to determine a baseline, median, and negative statistical outliers. The state will track and trend critical incidents that involve beneficiaries at the PIHP level: baseline, then identify negative statistical outliers. And track and trend requests for Medicaid Fair Hearing by beneficiaries, and track and trend by PIHP the Fair Hearing decisions that are found in favor of the beneficiary.

d) majority of the performance indicators are the same: the majority of the performance measures associated with CMS assurances are the same.

The provider network is the same across the 1915(i) and waiver programs. All provider types (i.e. licensed/non-licensed, certified/non-certified) within the 1915(i) and the waivers are required to meet the same training and background check requirements according to policy in order to furnish HCBS. Provider oversight is the same across the 1915(i) and waivers and all services are included in the consolidated reporting.

2. Roles and Responsibilities

MDHHs maintains overall responsibility for quality assurance, quality improvements and quality performance.

The Quality Improvement Council (QIC) has primary responsibility for identifying and prioritizing needs related to the Quality Improvement Strategy (QIS), which would include changes to 1915(i) system processes as applicable. The Quality Improvement Council meets every other month basis to review data and information from numerous sources, such as site review findings, 372 reports, state-level workgroups for practice improvement, EQR standard and special project reports, legislative reports, and performance improvement plan activities. The QIC determines where there are needs for system improvement and makes recommendations to MDHHS to incorporate into system improvement activities. The timeframe for incorporating changes is dependent on whether it is an issue requiring immediate enactment which would be addressed through policy changes or an amendment to the MDHHS/CMHSP and MDHHS/PIHP contracts. Otherwise, changes to the QIS are generally implemented in conjunction with the annual contracts between MDHHS and the PIHPs and CMHPS. The Quality Management Program (QMP) incorporates all of the programs operated in the public mental health system, including the §1115 Behavioral Health Demonstration, Habilitation Support Waiver (HSW), Children's Waiver Program (CWP), the Waiver for Children with Serious Emotional Disturbance (SEDW) and the 1915(i) State plan. The PIHPs/CMHSPs adhere to the same standards of care for each beneficiary served and the same data is collected for all beneficiaries regardless of funding source. The MDHHS QMP Site Review team conducts comprehensive biennial reviews at each PIHP (and affiliate CMHSPs). During the alternate years, QMP staff visit PIHP/CMHSPs to follow-up on implementation of plans of correction resulting from the previous year's comprehensive review. This site visit strategy includes rigorous standards for assuring the needs, including health and welfare, of 1915(i) participants are addressed. The comprehensive reviews include clinical record reviews, administrative reviews, consumer/stakeholder meetings and consumer interviews. In addition to identifying individual issues that are addressed in remediation, the QMP findings are also used for identifying trends to

implement systems improvements. This site visit strategy covers all consumers served by 1915(i) services with rigorous standards for assuring the health and welfare of the enrolled beneficiaries.

The comprehensive reviews include the clinical record reviews; review of personnel records to ensure the all providers meet provider qualifications and have completed training prior as required by policy as published in the Michigan Medicaid Provider Manual; review of service claims to ensure that the services billed were identified in the IPOS as appropriate to identified needs; review of the Critical Incident Reporting System and verification that the process is being implemented per MDHHS policy; review and verification that Behavior Treatment Plan Review Committees are operated per MDHHS policy; follow up on reported critical incidents regarding medication errors and monitoring to assure the PIHPs/CMHSPs are not using restraints or seclusion as defined in Michigan's Mental Health Code. As identified throughout this application, the biennial site review is the data source for discovery and remediation for a number of Performance Measures. MDHHS staff complete a proportionate random stratified sample at the 95% confidence level for the biennial review for each PIHP. At the on-site review, clinical record reviews are completed to determine that the IPOS: Includes services and supports that align with and address all assessed needs, addresses health and safety risks, is developed in accordance with MDHHS policy and procedures, including utilizing person centered/family-driven youth guided planning, and is updated at least annually.
Clinical record reviews are also completed to determine that participants are afforded choice between 1915(i) services and between/among service providers and that services are provided as identified in the IPOS.
QMP staff conduct consumer interviews with a random sample of those individuals whose clinical records were reviewed, using a standard protocol that contains questions about such topics as awareness of grievance and appeals mechanisms, person-centered planning and satisfaction with services. Interviews are conducted with beneficiaries who reside in group homes or are living independently with intense and continuous in-home staff or in the homes of families served by the 1915(i) services.

Contracted entities will conduct record reviews and participant satisfaction surveys. These entities will be responsible for providing technical assistance when identified in the performance of their duties. The contracted entities also retain responsibility to identify areas in need of improvement and make MDHHS aware of any identified trends or areas that need immediate remediation.

Providers are responsible for furnishing services according to MDHHS policies and procedures and for continuously improving their performance and the experiences of the individuals they serve. They retain responsibility for submitting claims to MDHHS for adjudication and for assuring all claims for service are provided according to established policies and procedures.

3. Frequency

MDHHS will monitor plans pf service, claims submitted for1915(i) services and the qualifications of providers biennially through the PIHP site review process.
Case record reviews will be conducted biennially on a statistically significant number of records across all 1915(i) enrollees.

4. Method for Evaluating Effectiveness of System Changes

MDHHS will utilize a number of sources to analyze effectiveness of system changes, including but not limited to site reviews, performance indicators, encounter data, critical incident data and Medicaid Fair Hearing data. Data will be analyzed at least to determine whether changes implemented led to improved outcomes for the individuals using 1915(i) services.

When issues are identified, a study of the root cause of the issue will be conducted. Any barriers to success identified will be removed or overcome to facilitate quality improvements.

Methods and Standards for Establishing Payment Rates

1. Services Provided Under Section 1915(i) of the Social Security Act. For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☑	HCBS Habilitation Community Living Supports
	Concurrent 1115 AND 1915 (i) authorities will utilize a capitated payment arrangement for this service. The capitation will be described in the State's 1115 waiver and approved contract consistent with 42 CFR 438.6(c).
☑	HCBS Respite Care
	Concurrent 1115 AND 1915 (i) authorities will utilize a capitated payment arrangement for this service. The capitation will be described in the State's 1115 waiver and approved contract consistent with 42 CFR 438.6(c).
For Individuals with Chronic Mental Illness, the following services:	
☐	HCBS Day Treatment or Other Partial Hospitalization Services
☐	HCBS Psychosocial Rehabilitation
☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☑	Other Services (specify below)
	The 1915(i) is being implemented concurrent with an 1115 authority for managed care. Concurrent 1115 AND 1915 (i) authorities will utilize a capitated payment arrangement for all the 1915 (i) HCBS's. The capitation will be described in the State's 1115 waiver and approved contract consistent with 42 CFR 438.6(c).

☑	**Environmental Modifications** Concurrent 1115 AND 1915 (i) authorities will utilize a capitated payment arrangement for this service. The capitation will be described in the State's 1115 waiver and approved contract consistent with 42 CFR 438.6(c). Michigan has not established a reimbursement structure for this service as the cost of this service is subject to wide variation based upon the type of modification needed. MDHHS will require PIHP prior authorization of all home modifications in accordance with established policy.
☑	**Enhanced Pharmacy** Concurrent 1115 AND 1915 (i) authorities will utilize a capitated payment arrangement for this service. The capitation will be described in the State's 1115 waiver and approved contract consistent with 42 CFR 438.6(c).
☑	**Family Support & Training** Concurrent 1115 AND 1915 (i) authorities will utilize a capitated payment arrangement for this service. The capitation will be described in the State's 1115 waiver and approved contract consistent with 42 CFR 438.6(c).
☑	**Fiscal Intermediary** Concurrent 1115 AND 1915 (i) authorities will utilize a capitated payment arrangement for this service. The capitation will be described in the State's 1115 waiver and approved contract consistent with 42 CFR 438.6(c).
☑	**Housing Assistance** Concurrent 1115 AND 1915 (i) authorities will utilize a capitated payment arrangement for this service. The capitation will be described in the State's 1115 waiver and approved contract consistent with 42 CFR 438.6(c).
☑	**Skill-Building Assistance** Concurrent 1115 AND 1915 (i) authorities will utilize a capitated payment arrangement for this service. The capitation will be described in the State's 1115 waiver and approved contract consistent with 42 CFR 438.6(c).
☑	**Specialized Medical Equipment & Supplies** Concurrent 1115 AND 1915 (i) authorities will utilize a capitated payment arrangement for this service. The capitation will be described in the State's 1115 waiver and approved contract consistent with 42 CFR 438.6(c). Michigan has not established a reimbursement structure for this service as the cost of this service is subject to wide variation based upon the type of equipment and supplies needed. MDHHS will require PIHP prior authorization of all equipment and supplies.
☑	**Supported/Integrated Employment** Concurrent 1115 AND 1915 (i) authorities will utilize a capitated payment arrangement for this service. The capitation will be described in the State's 1115 waiver and approved contract consistent with 42 CFR 438.6(c).
☑	**Vehicle Modification** Concurrent 1115 AND 1915 (i) authorities will utilize a capitated payment arrangement for this service. The capitation will be described in the State's 1115 waiver and approved contract consistent with 42 CFR 438.6(c). Michigan has not established a reimbursement structure for this service as the cost of this service is subject to wide variation based upon the type of modification needed. MDHHS will require PIHP prior authorization of all vehicle modification according to established policy.