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State/Territory Name: **Michigan**

State Plan Amendment (SPA) #: **23-0010**

This file contains the following documents in the order listed:

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

Medicaid and CHIP Operations Group

September 28, 2023

Farah Hanley, Chief Deputy Director
Behavioral and Physical Health and Aging Services Administration
Office of Strategic Partnerships & Medicaid Administrative Services – Federal Liaison
Capitol Commons Center – 7th Floor
400 South Pine
Lansing, Michigan 48933

RE: MI-23-0010 Nursing Facility Transition §1915(i) Home and Community-Based Services State Plan Benefit Renewal

Dear Deputy Director Hanley:

The Centers for Medicare & Medicaid Services (CMS) is approving the state's 1915(i) state plan home and community-based services (HCBS) state plan amendment (SPA), transmittal number MI-23-0010. The purpose of this amendment is to renew Michigan's 1915(i) State Plan HCBS benefit. The effective date for this renewal is October 01, 2023. Enclosed is a copy of the approved SPA.

Since the state has elected to target the population who can receive these §1915(i) State Plan HCBS, CMS approves this SPA for a five-year period expiring September 30, 2028, in accordance with §1915(i)(7) of the Social Security Act. To renew the §1915(i) State Plan HCBS 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.

Per 42 CFR §441.745(a)(i), the state will 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 21 months prior to the end of the five-year approval period, the state must submit evidence of the state's quality monitoring in accordance with the Quality Improvement Strategy in their approved SPA. The evidence must include data analysis, findings, remediation, and describe any system improvement for each of the §1915(i) requirements.

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

It is important to note that CMS' approval of this 1915(i) HCBS state plan benefit renewal solely addresses the state's compliance with the applicable Medicaid authorities. CMS' approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

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

Sincerely,

[redacted]

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

Enclosure

cc:
Deanna Clark, CMS
Deborah Benson, CMS
Keri Toback, CMS

DEPARTMENT OF HEALTH ANDHUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23 — 0010

2. STATE: MI

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

3. PROPOSED EFFECTIVE DATE
October 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 440.225 and 42 CFR 440.170(a)

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $0
b. FFY 2025 $0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-i.1, Pages 1 through 51
Attachment 4.19-B, Pages 25 through 26

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-i.1, Pages 1 through 51
Attachment 4.19-B, Pages 25 through 26
(TN# 18-0008)

9. SUBJECT OF AMENDMENT
This 1915(i) SPA renews authorization for the provision of nursing facility transition services to individuals who currently reside in a nursing facility and have expressed a desire to return to the community, but who have barriers to a nursing facility discharge.

10. 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:

[redacted] AGENCY OFFICIAL

11. TYPED NAME
Farah Hanley

12. TITLE
Chief Deputy Director for Health

13. DATE SUBMITTED
March 31, 2023

15. RETURN TO

Behavioral and Physical Health and Aging Services Administration
Office of Strategic Partnerships & Medicaid Administrative Services – Federal Liaison
Capitol Commons Center – 7th Floor
400 South Pine
Lansing, Michigan 48933

Attn: Erin Black

FOR CMS USE ONLY

16. DATE RECEIVED
04/03/2023

17. DATE APPROVED
09/28/2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
10/01/2023

19. SIGNATURE OF APPROVI [redacted]

20. TYPED NAME OF APPROVING OFFICIAL
George Failla Jr.

21. TITLE OF APPROVING OFFICIAL
Director of Home & Community Based Services Operations

22. REMARKS

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):*

Transition Navigator Case Management Services, Community Transition Services, Non-Medical (Non-Emergency) Transportation, Home Modifications, HCBS Personal Care

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

***Select one*:**

✓	**Not applicable**
O	**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:*
☐	**A program authorized under §1115 of the Act.** *Specify the program*:

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

✓	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.*	Behavioral and Physical Health and Aging Services Administration Bureau of Aging and Community Living Services Aging and Community-Services Division Home and Community Based Services Section
○	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.

✓ *(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*):

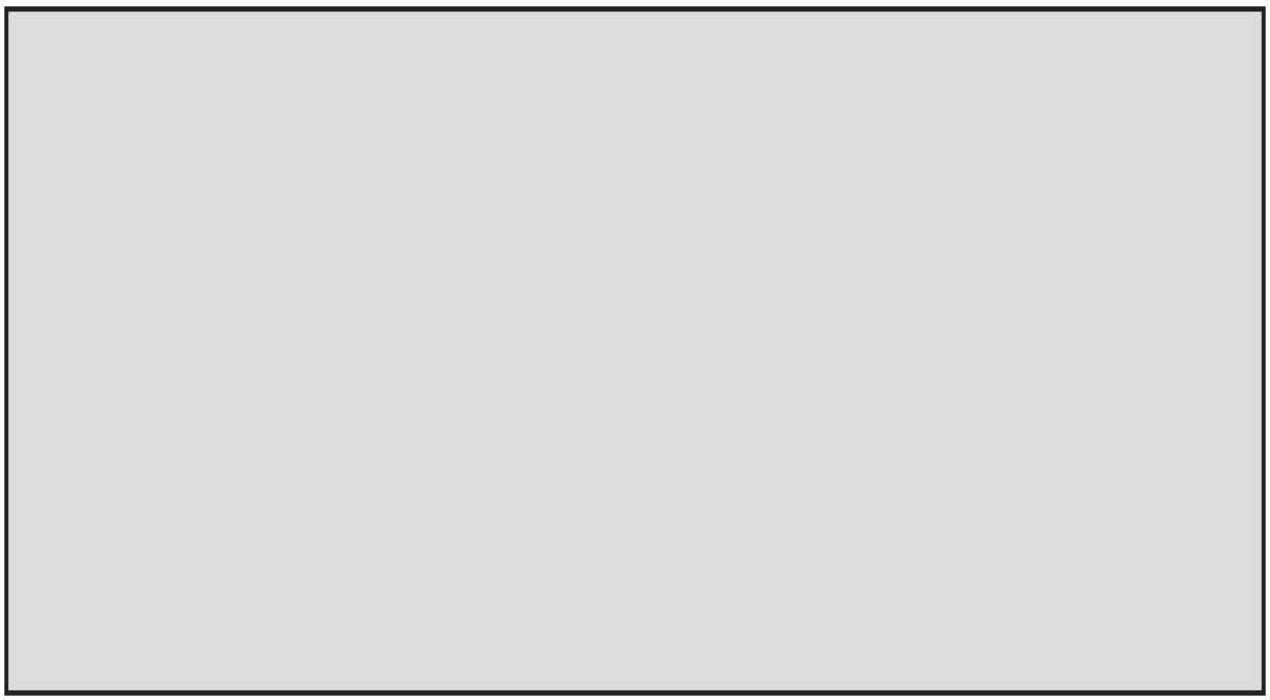
Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☐	☐	☐
2 Eligibility evaluation	☑	✓	☐	☐
3 Review of participant service plans	☑	☐	☐	☐
4 Prior authorization of State plan HCBS	☑	☐	☐	☐
5 Utilization management	☑	☐	☐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

Michigan Department of Health and Human Services (MDHHS), local offices establish Medicaid eligibility. MDHHS is the State Medicaid Agency. MDHHS uses contracted entities to conduct participant satisfaction and quality of life surveys. Local non-state entities that provide 1915(i) services will ensure the quality of staff and their client records and implement corrective action plans as required.

(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):*



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	10/1/2023	9/30/2024	2150
Year 2	10/1/2024	9/30/2025	2175
Year 3	10/1/2025	9/30/2026	2225
Year 4	10/1/2026	9/30/2027	2275
Year 5	10/1/2027	9/30/2028	2300

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*):

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 bachelor's degree, preferably in a health or social services field. Staff are trained in the needs-based criteria outlined for these State Plan services so that they can evaluate documentation and determine whether each applicant meets these criteria.

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:

Transition Navigators obtain information from applicants using the Community Transition Assessment tool, which is the instrument used to make this determination. Through completion of this tool, the transition navigator assesses the individuals' needs. The assessment tool contains information about the individual's ability to perform ADLs and IADLs, informal support network, goals for community living, and available resources. MDHHS staff review the assessments to verify the individual has Medicaid eligibility and to determine if the individual meets the needs-based criteria.

When MDHHS does not have enough information to make an eligibility determination, MDHHS staff requests additional information from the Transition Navigator. MDHHS reserves the right to evaluate the applicant in person to confirm the individual meets all eligibility requirements for 1915(i) services.

During the reevaluation, transition navigators update the Community Transition Assessment Tool. MDHHS staff review the assessment to verify the individual continues to have Medicaid eligibility and to determine if the individual meets the needs-based criteria for continued receipt of 1915(i) service(s).

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 minimally meet one of the criteria listed below:

Door A: "Activities of Daily Living" - The individual requires assistance to perform at least one activity of daily living or instrumental activity of daily living. Activities of daily living include bed mobility, transfers, toilet use, eating, dressing, personal hygiene, bathing, and locomotion. Instrumental activities of daily living include shopping, cooking, managing medications, using the phone, housework, laundry, public transportation, and managing finances; **OR**

Door B: "Cognitive Performance" - The individual meets one of the following:

- Needs minimal assistance in making safe decisions in familiar situations, but experiences some difficulty in decision-making when faced with new tasks or situations due to a short-term memory problem; or
- Is assessed with some difficulty making decisions in new situations or makes poor or unsafe decisions in recurring situations; or
- Is assessed to be usually understood and needs assistance (i.e. little or no prompting) finding the right words or finishing thoughts due to a short-term memory problem; **OR**

Door C: "Behavior" - The individual is assessed to have required assistance managing one of the following challenging behaviors in the last seven (7) days: wandering, verbally abusive, physically abusive, socially inappropriate/disruptive, or resisted care.

The individual who minimally meets the needs-based criteria above must also either:

1) Be at risk of inappropriate institutionalization because the individual is being served in an institution, but does not meet the level of care for that institution. **OR**
2) Indicate they have changed their minds about where they choose to receive long-term services and supports by indicating they no longer choose to receive services in the institutional setting on a Freedom of Choice form. **OR**
3) The beneficiary does not currently reside in a nursing facility or other institution but is at risk of returning to the nursing facility without the provision of services in this 1915(i) benefit.

AND have at least one of the following risk factors:

1. History or at risk of inability to secure or retain housing in the community.
2. History or at risk of inability to secure home and community-based services without assistance.
3. History or at risk of inability to secure documentation needed for independent living without assistance, including identification cards, health insurance cards, birth certificate, etc.
4. History of an unsafe or inaccessible living environment.

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)
See #5 above:	Must meet nursing facility level of care, e.g. demonstrate 1) Need for assistance with ADLs of bed mobility, transfers, toilet use, or eating, OR 2) Cognitive Performance deficits, a. Severely impaired in decision making, b. Short-term memory problem and at least moderately impaired in decision making, c. Short-term memory problem and is sometimes or rarely understood OR 3) Physician involvement with unstable medical condition within the last 14 days, OR 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 changes, or peritoneal or hemodialysis, OR	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.

	5) Received at least 45 minutes of skilled speech, occupational or physical rehabilitation therapies in the last 7 days, OR 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. OR 7) Be an LTSS participant for a year or more and have service dependency, OR 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)*):

Aged and Disabled Group:

- Aged = persons aged 65 and older
- Disabled = persons aged 18 through 64 with a physical disability

When individuals initially qualify as disabled, they will automatically qualify as aged upon their 65th birthday.

☐ **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: 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.)

Home and Community-Based Settings are applicable to individuals receiving the Community Transition Services in this 1915(i) benefit after they have transitioned out of the nursing facility. Individuals who transition out of the nursing facility may move into any of the following residential provider-controlled settings: Licensed Adult Foster Care Home, Licensed Home for the Aged, or an unlicensed Assisted Living Facility. The services in this 1915(i) benefit do not include provider controlled or operated non-residential settings. When an individual decides to move to one of these provider-controlled or operated settings, the transition navigator must first check with MDHHS to determine if the setting has already been determined to be compliant with the HCBS rule. If so, the individual may move to the setting and continue to receive 1915(i) benefits if they remain eligible for them.

In many cases, the individual will enroll in a different home and community-based services program upon transitioning out of the nursing facility. When this happens, the HCBS program maintains responsibility for assuring the residential setting maintains compliance with the HCBS rule and for ongoing monitoring. When individuals enroll in a HCBS program upon transition, community transition services end within 30 days of the transition.

When the setting in which the individual wishes to reside is not already deemed compliant with the HCBS rule AND the individual is not enrolling in a different HCBS program, the transition navigation agency will visit the residential setting and complete the "Residential Survey for MI Choice Waiver" to assess compliance to the HCBS Rule. This survey is available here: https://www.michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/beneficiaries/programs/progbens/mi-choice-waiver-program which includes all the required settings criteria and has been approved by CMS. Once the transition navigation agency completes it's assessment and the survey, it sends the completed survey to MDHHS for review and approval. Upon receipt, MDHHS reviews the survey results to determine compliance based upon the responses within the survey. If any questions arise, or if for any reason MDHHS cannot determine compliance, MDHHS will contact the setting and if needed, conduct it's own on-site visit. Once MDHHS is satisfied that the setting is compliant with the Federal home and community-based settings requirements, it will deem the setting compliant and notify the transition navigator.

The transition navigator is responsible for assuring continued compliance of the setting if there is a participant receiving services within these 1915(i) benefits. Minimally, the transition agency will reassess each provider controlled or owned setting annually and submit the results to MDHHS to affirm continued compliance. If for any reason, at any time, the setting is no longer compliant, immediate corrective action is required. The setting will have up to 30 days to return to compliance. The transition navigator will immediately inform the participant(s) residing in the setting of their option to remain in a non-compliant setting and terminate their 1915(i) benefits or move to a compliant setting. If the participant chooses to move, the transition navigator will assist with the relocation efforts. If the setting regains compliance, the participant may remain in the setting.

If needed, the setting will go through the heightened scrutiny process. Additional information about approval of new settings is detailed in Section 3 of the Home and Community Based Services Chapter of the Medicaid Provider Manual, available here: https://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf.

If the chosen setting does not wish to comply with the HCBS rule, the transition navigator will provide information on other settings in the area that meet compliance. If the individual still chooses to move to a non-compliant setting, the transition navigator will explain to the individual that 1915(i) benefits will need to end upon moving to that setting.

When an individual moves to a setting that is compliant with the HCBS Rule, does not enroll in a different HCBS program, and continues to be eligible for 1915(i) benefits, the transition navigator will monitor the setting for continued compliance at least annually using the "Residential Survey for MI Choice Waiver" tool and as defined in the Home and Community-Based Services Chapter of the Medicaid Provider Manual. All residential settings that are found to be out of compliance will require immediate corrective action to regain compliance.

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):*

Transition Navigators are qualified as a:

1) Registered Nurse licensed in the State of Michigan, or
2) Social Worker licensed in the State of Michigan, or
3) Non-licensed or other licensed health care professionals with the following qualifications:
    i. A bachelor's degree in a health or human services field or Community Health Worker certification, and
    ii. At least three years of experience in the provision of health or social services.

Transition Navigators must be knowledgeable in person-centered planning, how to access long-term and HCBS services and supports within the community they serve, how to address barriers to discharge, and eligibility requirements for HCBS services and supports.

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):*

Transition Navigators are qualified as a:

1) Registered Nurse licensed in the State of Michigan, or
2) Social Worker licensed in the State of Michigan, or
3) Non-licensed or other licensed health care professionals with the following qualifications:
   iii. A bachelor's degree in a health or human services field or Community Health Worker certification, and
   iv. At least three years of experience in the provision of health or social services.

Transition Navigators must be knowledgeable in person-centered planning, how to access long-term and HCBS services and supports within the community they serve, how to address barriers to discharge, and eligibility requirements for HCBS services and supports.

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) The Transition Navigator informs the individual of service options available to assist with a community transition and potentially available to the individual in the community. The Community Transition Assessment (CTA) is comprehensive and includes the identification of barriers, how the individual would like to overcome those barriers, what the individual's goals for community living are, how those goals will be achieved, and examines HCBS that are available to the individual. The Transition Navigator discusses options with the individual. The Transition Navigator also serves to link the individual with other specialists who may assist with specific barriers, such as locating affordable housing options, or accessing specific services (e.g. Veteran's Benefits). The Transition Navigator describes the services and supports available through the community transition services and informs the individual of issues that should be addressed as identified through the assessment process. During the completion of the CTA, the Transition Navigator is responsible for discussing options for the participant to receive services identified on the person-centered service plan and recording the participant's goals and preferences.

b) The participant has full authority to determine who facilitates the person-centered plan, who to include in the person-centered planning process, who to exclude from the process, and ultimately what services, goals, and outcomes are included in the person-centered service plan. All providers responsible for implementation of the

person-centered service plan will sign and receive a copy of the plan, or of their portion of the plan (as preferred by the participant).

The Transition Navigator works with the individual and their representatives to develop the initial person-centered service plan. The first person-centered planning meeting occurs when the participant is not in crisis and at a time of the participant's choice.

A pre-planning session may occur before the first person-centered planning meeting. During pre-planning, the participant chooses dreams, goals and any topics to discuss, who to invite, who will facilitate and record the meeting, as well as a time and location that meets the needs of all individuals involved in the process. The participant and selected allies design the agenda for the person-centered planning meeting. The person-centered service plan is based on the expressed needs and desires of the participant and is updated upon request of the participant. Regular updates to the service plan occur when the need for services or participant circumstances change, but at least once every year.

MDHHS has a person-centered planning practice guide. The document is available on the MDHHS website (https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder4/Folder41/Folder3/Folder141/Folder2/Folder241/Folder1/Folder341/Person-Centered_Planning_Practice_Guidance.pdf?rev=6cb6ae07af704dab85f08481447ab5c4&hash=67A902B1991E8ECBD8DEF078FA9C9EE8) to assist Transition Navigators in ensuring that the person-centered service plan clearly identifies the individual's needs, goals and preferences with the services specified to meet them.

The Transition Navigator and participant base the person-centered service plan upon participant preferences, goals, and needs identified through the person-centered planning process. A written person-centered service plan is developed with each participant and includes the participant's identified or expressed needs, goals, expected outcomes, and planned interventions, regardless of funding source. This document includes all services and supports provided to or needed by the individual to implement their service plan and community living goals. Transition Navigators arrange services and supports based upon the individual's choice and approval. The individual and Transition Navigator explore other funding options and intervention opportunities when personal goals include things beyond the scope of Medicaid-funded services.

The service plan clearly identifies the types of services and supports needed from both paid and non-paid providers. The amount (units), frequency, and duration of each service are included in the person-centered service plan. The individual chooses the services that best meet their needs. The Transition Navigator ensures implementation and provision of the services and supports according to the person-centered service plan. Transition Navigators oversee the coordination of State Plan and other services included in the person-centered service plan. This oversight

ensures that services and supports included in the person-centered service plan are not duplicative.

The assignment of responsibilities to implement the service plan are determined through person-centered planning and may be delegated to the individual, Transition Navigator, or others designated by the individual. The Transition Navigator and the individual, to the extent the individual chooses, are responsible for monitoring the person-centered service plan. This occurs through periodic case reviews, monthly contacts, individual requests, reassessments, and routine monitoring.

Transition Navigators periodically meet with the individual for a reassessment to identify changes that may have occurred since the initial assessment or the last meeting and to measure progress toward meeting specific goals outlined in the individual's service plan. The individual may choose to have additional face-to-face meetings to focus specifically on the person-centered service plan at any time. The service plan is reviewed and updated during this process, based upon reassessment findings and participant preferences. The service plan is updated after changes in status and upon request.

Transition Navigators identify and discuss potential risks to the individual during the assessments, reassessments, and planning meetings. The person-centered planning process specifies risks and methods of monitoring their potential impact in conjunction with the individual. The Transition Navigator, or other qualified individuals, fully discuss strategies to mitigate risks with the individual and allies, family, and relevant others during person-centered planning. Risk strategies approved by the individual are written into the person-centered service plan. Individuals may be required to acknowledge situations in which their choices pose risks for their health and welfare. The Transition Navigator is not obligated to authorize services or supports believed to be harmful to the participant. Negotiations of such issues are initiated in the person-centered planning process. Transition Navigators assess and inform individuals of their identified potential risk(s) to assist them in making informed choices regarding these risks.

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):*

MDHHS established a toll-free number for information about 1915(i) services. MDHHS and its contracted providers distribute marketing materials about the program. The toll-free number is answered by a third-party vendor, Mi ENROLLS. Individuals who call the number are provided basic information about 1915(i) services and offered information about transition agencies that serve their county. Contact information may be given over the telephone or mailed to the individual based upon their preferences. If the caller wishes to have more detailed information, MDHHS staff provide that information to the caller with a return call.

This toll-free number also takes complaints from callers, which are followed up by MDHHS staff. This number is published on State-approved brochures and the MDHHS website regarding these services and will be disseminated widely.

Additionally, the Transition Navigator informs the individual of available 1915(i) services to overcome barriers to discharging from the nursing facility. This occurs through direct communication and written information (approved by MDHHS) provided to the individual regarding 1915(i) services and other HCBS programs. The individual receives information on all potential service providers. The individual specifies how he/she wishes to receive services and from whom, and this is included in the person-centered service plan.

MDHHS has Medicaid provider agreements with community-based organizations (CBOs) to deliver transition navigation services to interested individuals.
CBOs are non-governmental agencies such as Area Agencies on Aging, Centers for Independent Living, and other community-based organizations. These entities employ qualified transition navigators to act as case managers for these 1915(i) benefits. Each transition navigator is a Medicaid-enrolled provider and MDHHS approves each enrollment only upon confirmation of their qualifications. The transition navigators are not required to be a part of the CBO.
Each transition navigation provider including CBOs may also directly provide 1915(i) Community Transition Services. Typically, the transition navigators arrange for the direct purchase of goods and services by their CBO for items and services that fall within the Community Transition Services benefit as there would be no other way to pay for the items and services included within the service definition since entities that offer these items and services are not Medicaid-enrolled providers and therefore cannot bill for reimbursement directly. This includes retail stores, utility companies, proprietors, pest control agencies, etc. Participants choose the items they prefer by making selections online, discussing preferences during person-centered planning meetings, making lists with the transition navigator, and/or accompanying the transition navigator to the retail store.

The CBOs also have Medicaid provider agreements to operate as an organized health care delivery system (OHCDS) pursuant to 42 CFR §447.10. Under this arrangement, they contract with other providers that furnish 1915(i) home modifications, non-medical non-emergency transportation, and personal care services so that the CBO will reimburse the entity performing the service and then submit a claim to MDHHS for the services provided. Upon approval of the claim, MDHHS then reimburses the CBO. The CBO assures the services are furnished by qualified providers and according to the person-centered service plan. The CBOs are required to offer beneficiaries free choice of provider and are prohibited from contracting with entities who are directly affiliated with or subsidiaries of the CBO.

All 1915(i) providers may directly enroll with, submit claims to, and receive payment from MDHHS if they do not wish to work with the CBO OHCDS. Beneficiaries are allowed to choose from any enrolled provider for each 1915(i) service on the person-

centered service plan. If a participant prefers a provider that does not work with the CBO/OHCDS, MDHHS will work directly with the chosen provider to ensure the provider is qualified and enrolled in CHAMPS (Michigan's MMIS). MDHHS may also provide listings of enrolled providers to participants as needed.

MDHHS also has a Community Transition Services Participant Handbook that is provided to each beneficiary. The handbook and other program information is located at the Community Transition Services webpage: https://www.michigan.gov/mdhhs/doing-business/providers/providers/billingreimbursement/community-transition-services. This handbook includes information on how to file complaints, grievances, how to request a State Fair Hearing, and how to access the Community Transition Services Ombudsman Program. Furthermore, there is information on how to file a Section 1557 complaint and a US DHHS complaint. These are all forms of accessible alternative dispute resolution processes.

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):*

MDHHS has a NFT Portal to manage all individuals who receive 1915(i) services. Transition Navigators upload the CTA and person-centered service plan in the secure portal for MDHHS review and approval. MDHHS staff compare the person-centered service plan 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 of the plan. All services are prior authorized to assure their appropriateness before they are furnished. State staff review prior authorization requests and approve requests that are deemed appropriate.

MDHHS staff conduct record reviews continuously through the prior authorization process on all case records for 1915(i) services. This review focuses on the appropriateness of 1915(i) services included in the person-centered service plan and provided to the individual. Any services found to be inappropriate will not be prior authorized and may be subject to recovery through this process.

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):*				

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:	Transition Navigator Case Management Services
Service Definition (Scope):	

This service is available while in the institution and the community. Participants may receive transition navigator services up to 180 consecutive days prior to discharge, but FFP will not be claimed until the individual transitions from the nursing home

Transition Navigator services are provided to assure the delivery of supports and services needed to meet the individual's goals for living in the community after an institutionalization. Without these supports and services, the individual may be at risk of inappropriate institutionalization because the individual does not meet the level of care for that institution or because the individual has chosen a different setting in which to receive their long term services and supports. The Transition Navigator functions to be performed and the frequency of face-to-face and other contacts are specified in the individual's person-centered service plan. The frequency and scope of Transition Navigation contacts must take into consideration health and welfare needs of the individual. Transition Navigation may include the direct provision of Community Transition Services as specified in the person-centered service plan.

Functions performed by a Transition Navigator include the following:

1. Conducting the initial and subsequent needs-based criteria evaluation and community transition assessment and providing that evaluation to MDHHS for approval.
2. Supporting a person-centered planning process that is
   a. focused on the individual's preferences,
   b. includes family and other allies as determined by the individual,
   c. identifies the individual's goals, preferences and needs,
   d. provides information about options, and
   e. engages the individual in monitoring and evaluating services and supports.
3. Developing a person-centered service plan with the beneficiary using the person-centered planning process, including revisions to the plan at the individual's initiation or as changes in the individual's circumstances may warrant.
4. Referral to and coordination with providers of home and community-based services and supports, including non-Medicaid services and informal supports. This may include helping with access to entitlements or legal representation.
5. Monitoring of the services and supports identified in the person-centered service plan for achievement of the individual's goals. Monitoring includes opportunities

for the individual to evaluate the quality of services received and whether those services achieved desired outcomes. This activity includes the individual and other key sources of information as determined by the individual.

6. Providing social and emotional support to the individual and allies to facilitate life adjustments and reinforce the individual's sources of support. This may include arranging services to meet those needs.
7. Providing advocacy in support of the individual's access to benefits, assuring the individual's rights as a Medicaid beneficiary, and supporting the individual's decisions.
8. Monitoring the individual after the community transition to assure a successful adjustment to community life, including assuring access to and enrollment in needed HCBS programs.
9. Maintaining documentation of the above listed activities to ensure successful support of the individual, comply with Medicaid and other relevant policies, and meet quality assurance and quality improvement requirements.
10. Conducting a tenant screening and housing assessment with the beneficiary that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers.
11. Developing an individualized housing support plan with the beneficiary based upon the housing assessment that addresses identified barriers, includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal.
12. Assisting the individual with the housing search and application process.
13. Assisting the individual with identifying resources to cover expenses such as security deposit, moving costs, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses.
14. Ensuring that the living environment is safe and ready for move-in.
15. Assisting the individual in arranging for and supporting the details of the move.
16. Developing a housing support crisis plan with the beneficiary that includes prevention and early intervention services when housing is jeopardized.
17. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations.
18. Providing education and training on the role, rights and responsibilities of the tenant and landlord.
19. Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.
20. Assisting the individual in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action.
21. Assisting the individual with advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.
22. Assisting the individual with the housing recertification process.
23. Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.

24. Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.			
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):*
Nurse	RN		
Social Worker	LLSW, BSW, MSW		
Transition Navigator			Non-licensed or other licensed health care professionals with the following qualifications: a) A bachelor's degree in a health or human services field or Community Health Worker certification, and b) At least three years of experience in the provision of health or social 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):*
RN	**LARA, CHAMPS**	**Annually**
SW	**LARA, CHAMPS**	**Annually**
Transition Navigator	**CHAMPS**	**Annually**

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

☐	Participant-directed	✓	Provider managed

2. 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:	Community Transition Services
Service Definition (Scope):	
Community Transition Services are non-reoccurring expenses necessary to enable an individual who is transitioning from a nursing facility or other institutional setting to the community to establish a basic household and do not constitute room and board. This service is available while in the institution to prepare the individual's chosen home and to accommodate a successful transition to the community. This service may be available in the community when additional needs that were not accounted for prior to transition are identified. Expenses for these additional needs must be directly related to the individual's transition to the community from a nursing facility. MDDS will not claim FFP for this service until the individual transitions from the nursing facility. These services include the following: • Security deposits and fees to obtain a lease on an apartment or home, • Set-up fees for utilities or service access, including telephone, electricity, heating and water, • Essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens, • Services necessary for the individual's health and safety such as pest eradication, allergen control, and one-time cleaning prior to occupancy.	
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):*
	Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the person-centered service plan development process, clearly identified in the person-centered service plan and only when the person is unable to meet such expense or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversional/recreational purposes.
✓	Medically needy *(specify limits):*

	Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the person-centered service plan development process, clearly identified in the person-centered service plan and only when the person is unable to meet such expense or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversional/recreational purposes.

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

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Center for Independent Living			Enrolled as Medicaid Provider for 1915(i) services in CHAMPS
Area Agency on Aging			Enrolled as Medicaid Provider for 1915(i) services in CHAMPS
Community-Based Organization			Enrolled as Medicaid Provider for 1915(i) services in CHAMPS
Retail Stores			Items purchased from retail stores must meet the community transition services definition.
Contractor, Builder	Contractor's License, Builder's License		Must be licensed in Michigan

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)*:
Center for Independent Living	CHAMPS	Annually
Area Agency on Aging	CHAMPS	Annually
Community Based Organization	CHAMPS	Annually
Retail Stores	Center for Independent Living, Area Agency on Aging, or other Community Based Organization	Prior to furnishing services and annually thereafter.

Contractor, Builder	LARA	Annually

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

☐	Participant-directed	✓	Provider managed

3. **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:	Non-Medical (Non-Emergency) Transportation
Service Definition (Scope):	
Non-medical (Non-Emergency) transportation (NMNET) is offered to enable individuals to gain access to community services, activities and resources, specified by the individual's person-centered service plan. This service is available while in the community. Whenever possible, family, neighbors, friends, or community agencies that can provide transportation services without charge must be utilized before authorizing this transition service. NMNET Services may be provided while in the community to address issues identified on the person-centered service plan. This may include going to the grocery store, religious services, volunteering, or work. Non-Medical (Non-Emergency) Transportation services offered are not available through the State Plan and are in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State Plan, defined at 42 CFR 440.170(a).	
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):*

	1. The participant must use other available providers, including informal supports before non-medical transportation may be authorized. 2. This service does not include purchasing, leasing, repair, or maintenance on vehicles. 3. This service may not be authorized to reimburse caregivers to run errands for participants when the participant does not accompany the driver of the vehicle. The purpose of this service is to enable the participant to gain access to their community services, activities, and resources. 4. Reimbursement does not include expenses for meals or lodging incurred while traveling.
✓	Medically needy *(specify limits):*
	Same as Categorically needy.

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Individual (paid or volunteer)	Driver's license		Must be a licensed driver with a valid driver's license issued by the Michigan Secretary of State. All drivers must have vehicle insurance as required by the State of Michigan. All drivers must follow all motor vehicle laws. All passengers must comply with seat belt laws.
Public Transit	Driver's License for each driver		Must follow all applicable laws including licensure, inspections, and vehicle maintenance, etc.
Private Transportation Company	Driver's License for each driver		Must follow all applicable laws including licensure, inspections, insurance, and vehicle maintenance. Must include passenger assistance in the provision of service, when needed by passenger

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):*

Individual	Center for Independent Living, Area Agency on Aging, or other Community Based Organization	Annually
Individual Drivers	Secretary of State	Every 4 years (renewal of Driver's License)
Public Transit	Secretary of State	Annually
Private Transportation Company	Secretary of State	Annually

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

☐	Participant-directed	✓	Provider managed

4. **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:	Home Modifications
Service Definition (Scope):	
Home Modifications include physical adaptations to the home required by the participant's PCSP that are necessary to ensure the health and welfare of the participant or that enable the participant to function with greater independence in the home. Assessments and specialized training needed in conjunction with the home modification are included as a part of the cost of the service. This service is available while in the institution to prepare the individual's chosen home and to accommodate a successful discharge to the community. This service may be available in the community when additional needs that were not accounted for prior to transition are identified. MDHHS authorizes home modifications up to 180 consecutive days in advance of community transition from the nursing facility and will not claim FFP for this service until the individual transitions from the nursing facility. The services under the home modification service are limited to additional services not otherwise covered under the state plan, including EPSDT.	
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):*

Home modifications are limited to:

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

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

Home modifications will not be approved for rental properties without a close examination of the rental agreement and the proprietor's responsibility to furnish the modification.

The provider must comply with all local building codes, as applicable.

Home modifications are not available for condemned structures and must not result in valuation of the structure significantly above comparable neighborhood real estate values.

Home modifications cannot increase the square footage of the home.

Excluded home modifications are those that:

- Are of general utility
- Are considered standard housing obligations of the participant or homeowner; and
- Are not of direct medical or remedial benefit to the participant
- Examples of exclusions include, but are not limited to: carpeting, roof repairs, sidewalks, driveways, heating, central air conditioning, garages, raised garage doors, storage and organizers, hot tubs, whirlpool tubs, swimming pools, landscaping, and general home repairs or maintenance.

Home modifications exclude costs for improvements exclusively required to meet local building codes.

	The infrastructure of the home involved in the funded modification must comply with all applicable local codes and have the capability to accept and support the proposed changes. Home modifications required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for safe operation of the specified equipment and are not intended to correct existing code violations in the home. Home modifications exclude general construction costs in a new home or additions to a home purchased by the participant. If a participant or the participant's family purchases or builds a home while in the process of transitioning, it is the participant's or family's responsibility to assure the home will meet basic needs, such as having a ground floor bath or bedroom when the participant has mobility limitations. However, home modifications may include assistance with the adaptations noted above (e.g. ramps, grab bars, widening doorways, bathroom modifications) for a recently purchased home. If modifications are needed to a home under construction that require special adaptation to the plan (e.g. roll-in shower), the home modification service may be used to fund the difference between the standard fixture and the modification required to accommodate the participant's need.
✓	Medically needy *(specify limits):*
	Same as specified for categorically needy.

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Individual	MCL 339.601 (1) MCL 339.601.2401(1) MCL 339.601.2403(3)	Licensed builder or licensed contractor	
Retail Stores	n/a	n/a	Items purchased must meet the home modification service definition.
Agency or business	MCL 339.601 (1) MCL 339.601.2401(1)	Licensed builder or licensed contractor	

	MCL 339.601.2403(3)		

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)*:
Individual	Center for Independent Living, Area Agency on Aging, or other Community Based Organization	Prior to the provision of services and annually thereafter
Individual	LARA	Annually
Contractor	Center for Independent Living, Area Agency on Aging, or other Community Based Organization,	Prior to the provision of services and annually thereafter
Contractor	LARA	Annually
Retail Store	Center for Independent Living, Area Agency on Aging, or other Community Based Organization,	As needed

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

☐	Participant-directed	✓	Provider managed

5. **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:	HCBS Personal Care
Service Definition (Scope):	

Personal care services enable individuals with functional limitations, resulting from a medical or physical disability or cognitive impairment to live independently and receive care in the least restrictive setting preferred by the individual. Personal care includes the provision of assistance with activities of daily living (eating, toileting, bathing, grooming, dressing, transferring, and mobility) and instrumental activities of daily living (taking medication, meal preparation, shopping for food or other necessities, laundry, and housekeeping).

HCBS Personal Care Services provided while in the community are limited to individuals who are not eligible for State Plan Personal Care Services (Home Help) or who require personal care services to begin before State Plan Personal Care Services or other HCBS services (PACE, MI Health Link, MI Choice) can be authorized. At no time shall an individual receive both State Plan Personal Care Services and HCBS Personal Care

Services at the same time. HCBS Personal Care services may also be authorized when an individual's-needs change and they are unable to quickly secure other personal care services available through the State Plan or a waiver.

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

Individuals must be assessed to need hands-on assistance with at least one ADL to receive this service.

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):*

Services cannot duplicate, replace, or supplant other available state plan services. Individuals enrolled in another HCBS program (waiver or state plan) must receive personal care assistance or services through that program.

✓ Medically needy *(specify limits):*

Services cannot duplicate, replace, or supplant other available state plan services. Individuals enrolled in another HCBS program (waiver or state plan) must receive personal care assistance or services through that program.

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Individual	n/a	n/a	Must be enrolled in CHAMPS Must not have any excludable convictions based upon a background check. Individuals must be able to meet the needs of the participant as specified in the person-centered service plan
Agency	n/a	n/a	Must be enrolled in CHAMPS Employees and other key staff must not have any excludable convictions based upon a background check. Employees must be able to meet the needs of the participant as specified in the person-centered service plan.

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

Provider Type *(Specify)*:	Entity Responsible for Verification	Frequency of Verification *(Specify):*

	(Specify):	
Individual	Center for Independent Living, Area Agency on Aging, or other Community Based Organization	Prior to the provision of services and annually thereafter
Agency	Center for Independent Living, Area Agency on Aging, or other Community Based Organization	Prior to the provision of services and annually thereafter

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

☐	Participant-directed	✓	Provider managed

6. ☐ **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):*

Participant-Direction of Services

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

1. Election of Participant-Direction. (*Select 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):

3. Limited Implementation of Participant-Direction. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness 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
	☐	☐
	☐	☐

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):*

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.):*
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.*

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.

Requirement	*Service plans address assessed needs of 1915(i) participants*
Discovery	
Discovery Evidence *(Performance Measure)*	**Number and percent of individuals with a person-centered service plan that includes services and supports that align with their assessed needs and expressed goals.** **Numerator: Number of individuals with a person-centered service plan that includes services and supports that align with their assessed needs and expressed goals.** **Denominator: All person-centered service plans.**
Discovery Activity *(Source of Data & sample size)*	100% MDHHS will review all person-centered service plans to determine whether the plan includes services and supports that align with their assessed needs and expressed goals.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS will review each person-centered service plan developed by a transition navigator and submitted to MDHHS for approval. MDHHS must approve all service plans before services can be delivered. When MDHHS identifies a discrepancy between the assessment and the person-centered service plan, the transition navigator must make corrections to the assessment or plan to the satisfaction of MDHHS and the individual.
Frequency	Continuous and ongoing, compiled annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDHHS will collect, analyze, and aggregate remediation activities. This may require an in-person visit with the individual or may be a correction of an error or omission in the documentation submitted to MDHHS. The transition navigator will be required to submit corrected documents to MDHHS within 30 days of being notified of the needed corrections. Service providers will receive reports of the case record reviews and allowed 30 days to develop a corrective action plan for any deficiencies noted. MDHHS will monitor the implementation of the corrective action plan to assure quality improvements are realized. Any issues found that jeopardize the health or welfare of the individual will require immediate remediation to the satisfaction of the individual and MDHHS.

Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***Service plans are updated annually***
Discovery	
Discovery Evidence *(Performance Measure)*	**Number and percent of person-centered service plans updated at least annually or sooner if indicated.** **Numerator: Number of person-centered service plans updated at least annually or sooner if indicated.** **Denominator: All person-centered service plans open and active for at least 365 days.**
Discovery Activity *(Source of Data & sample size)*	MDHHS will monitor 100% of the person-centered service plans that have been approved for at least 365 days.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS reviews each person-centered service plan developed by a transition navigator and submitted to MDHHS for approval that remains open and active for 365 days or more. MDHHS verifies that these plans are updated at least annually, or sooner when indicated. When MDHHS identifies a plan that was not updated when it should have been, the transition navigator is required to make corrections to the plan to the satisfaction of MDHHS and the individual.
Frequency	Continuous and ongoing, compiled annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDHHS collects, analyzes, and aggregates remediation activities. Reviews occur annually for all person-centered service plans that remain open for at least 365 days. Service providers receive reports of the case record reviews and are allowed 30 days to develop a corrective action plan for any deficiencies noted. MDHHS monitors the implementation of the corrective action plan to assure quality improvements are realized. Any issues found that jeopardize the health or welfare of the individual require immediate remediation to the satisfaction of the individual and MDHHS.
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***Service plans document choice of services and providers.***
Discovery	
Discovery Evidence	**Number and percent of individuals with service plans that document choice of services and providers.**

(Performance Measure)	**Numerator: Number of individuals with service plans that document choice of services and choice of providers.** **Denominator: All service plans reviewed.**
Discovery Activity *(Source of Data & sample size)*	100% MDHHS reviews all person-centered service plans to determine whether the plan includes documentation of choices of services and providers for the individual.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS or a contracted entity will review each person-centered service plan developed by a transition navigator and submitted to MDHHS for approval to assure documentation includes the choices between services and service providers. When MDHHS identifies a discrepancy, the transition navigator will be required to make corrections to the plan to the satisfaction of MDHHS and the beneficiary.
Frequency	Continuous and ongoing, compiled annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDHHS collects, analyzes, and aggregates remediation activities. This may require an in-person visit with the individual or may just be a correction of an error or omission in the documentation submitted to MDHHS. The transition navigator is required to submit corrected documents to MDHHS within 30 days of being notified of the needed corrections. Service providers will receive reports of the case record reviews and are allowed 30 days to develop a corrective action plan for any deficiencies noted. MDHHS monitors the implementation of the corrective action plan to assure quality improvements are realized. Any issues found that jeopardize the health or welfare of the individual require immediate remediation to the satisfaction of the individual and MDHHS.
Frequency *(of Analysis and Aggregation)*	Annually

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.

Requirement	**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.**
Discovery	

Discovery Evidence *(Performance Measure)*	**Number and percent of 1915(i) services evaluations completed.** **Numerator: Number of 1915(i) services evaluations completed.** **Denominator: All 1915(i) services referrals received.**
Discovery Activity *(Source of Data & sample size)*	Transition agencies must track all referrals made to them and document the referral in the nursing facility transition portal. This data is available to MDHHS once it is entered in the nursing facility transition portal. The sample size is 100%.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS use referral and claims data for the number of evaluations completed to calculate this performance measure. When an agency is not completing a timely evaluation for referrals made, MDHHS requires corrective action of the entity.
Frequency	Continuous & ongoing, compiled annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDHHS collects, analyzes, and aggregates remediation activities. Reviews occur continuously. Service providers receive data reports and are allowed 30 days to explain discrepancies and develop a corrective action plan for any deficiencies noted. MDHHS monitors the implementation of the corrective action plan to assure quality improvements are realized quarterly. Any issues found that jeopardize the health or welfare of the individual require immediate remediation to the satisfaction of the individual and MDHHS.
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	**The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately.**
Discovery	
Discovery Evidence *(Performance Measure)*	**Number and percent of 1915(i) services evaluations made by a qualified evaluator using an approved instrument.** **Numerator: Number of 1915(i) services evaluations made by a qualified evaluator using an approved instrument.** **Denominator: All 1915(i) services records.**
Discovery Activity *(Source of Data & sample size)*	100% MDHHS reviews all 1915(i) case records to determine whether the evaluations were made by a qualified evaluator using the appropriate instrument.
Monitoring Responsibilities	MDHHS reviews the evaluations made to assure the appropriate instrument was used and a qualified evaluator completed the determination. When an evaluation is not completed properly, or someone who is not qualified to be a transition navigator completes an evaluation, MDHHS requires corrective action.

(Agency or entity that conducts discovery activities)	
Frequency	Continuous and ongoing, compiled annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDHHS collects, analyzes, and aggregates remediation activities. Reviews occur continuously and ongoing. Evaluators receive reports of the findings and are allowed 30 days to develop a corrective action plan for any deficiencies noted. MDHHS monitors the implementation of the corrective action plan to assure quality improvements are realized. Any issues found that jeopardize the health or welfare of the individual including having an evaluation completed by a non-qualified person, require immediate remediation to the satisfaction of the individual and MDHHS.
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***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)*	**The number and percent of individuals enrolled in 1915(i) services for more than a year who have had an annual reevaluation.** **Numerator: The number of individuals enrolled in 1915(i) services for more than a year who have had an annual reevaluation.** **Denominator: The number of individuals enrolled in 1915(i) services for more than a year.**
Discovery Activity *(Source of Data & sample size)*	MDHHS monitors all beneficiaries who have been enrolled in 1915(i) services for a year or more since the last evaluation. MDHHS assures that beneficiaries enrolled in 1915(i) services for longer than a year have an annual reevaluation. The sample size will be 100%.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS reviews the evaluations to assure the appropriate instrument was used and a qualified evaluator completed the determination. When an evaluation is not completed properly, MDHHS requires corrective action. Any issues found that jeopardize the health or welfare of the individual, including having an evaluation completed by a non-qualified person, require immediate remediation to the satisfaction of the individual and MDHHS.
Frequency	Continuous & ongoing
Remediation	

Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Evaluators serving individuals who have not had a reevaluation after being enrolled for a year are required to perform a reevaluation or discharge the individual. Case record documentation must assure the individual is making progress toward their goals of transitioning and participating in the community. Once a missed or late evaluations identified, reevaluations need to be conducted within one week.
Frequency *(of Analysis and Aggregation)*	Continuous & ongoing

3. Providers meet required qualifications.

Requirement	***Providers meet required qualifications***
Discovery	
Discovery Evidence *(Performance Measure)*	**Number and percent of non-licensed or non-certified 1915(i) services providers that meet provider qualifications.** **Numerator: Number of non-licensed or non-certified providers that meet provider qualifications.** **Denominator: All non-licensed or non-certified providers.**
Discovery Activity *(Source of Data & sample size)*	100% of non-licensed or non-certified providers, MDHHS/CHAMPS
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS monitors providers and assures that the proper documentation to verify provider qualifications is submitted to the Department as required. Provider end dates are be used to assure unqualified providers are not paid for services rendered.
Frequency	Continuous and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDHHS uses CHAMPS to analyze and aggregate the data. When a non-licensed, non-certified provider is found that does not meet provider qualifications, their provider eligibility is end dated in CHAMPS and they are no longer be able to bill for services provided to individuals. MDHHS recoups payments made to providers who were not qualified at the time of service provision.
Frequency	Continuous and ongoing.

(of Analysis and Aggregation)	

Requirement	***Providers meet required qualifications***
Discovery	
Discovery Evidence *(Performance Measure)*	**Number and percent of licensed or certified 1915(i) services providers that meet provider qualifications.** **Numerator: Number of licensed or certified providers that meet provider qualifications.** **Denominator: All licensed or certified providers.**
Discovery Activity *(Source of Data & sample size)*	100% of licensed or certified providers MDHHS/CHAMPS
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS monitors providers and assures the proper documentation to verify provider qualifications is submitted to the Department as required. Provider end dates are used to assure unqualified providers are not paid for services rendered.
Frequency	Continuous and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDHHS uses CHAMPS to analyze and aggregate the data. When a licensed or certified provider is found that does not meet provider qualifications, their provider eligibility is end dated in CHAMPS and they are no longer able to bill for services provided to individuals.
Frequency *(of Analysis and Aggregation)*	Continuous and ongoing.

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).

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 provider-controlled settings that meet the HCBS settings requirements used by individuals enrolled in 1915(i) services who have transitioned from an institution.** **Numerator: Number of provider-controlled settings that meet the HCBS settings requirements used by individuals enrolled in 1915(i) services who have transitioned from an institution.** **Denominator: All provider-controlled settings used by individuals enrolled in 1915(i) services who have transitioned from an institution.**
	Discovery Activity *(Source of Data & sample size)*	MDHHS monitors all individuals enrolled in 1915(i) services who have transitioned from an institution and chosen to use a provider-controlled setting in the community. All provider-controlled settings must meet the HCBS settings requirements in 42 CFR 441.710(a)(1) and (2) prior to the individual using that setting. The sample size is 100%.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS or Transition Navigators work with provider-controlled settings to assure they meet the HCBS settings rule before the individual uses a specific provider.
	Frequency	Continuous & ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Transition Navigators have access to an MDHHS database that identifies whether a provider-controlled setting has been evaluated for compliance to the HCBS settings rule, and if so, whether the setting meets the requirements. When individuals choose a setting that has not been deemed compliant, the Transition Navigator will need to inform the individual that 1915(i) services must stop upon transition to this setting and of other available options that are compliant where transition and other HCBS services could continue. Should the individual still choose a non-compliant setting, no Medicaid-funded reimbursement for services after the transition date will be approved.
	Frequency *(of Analysis and Aggregation)*	Continuous & ongoing

5. The SMA retains authority and responsibility for program operations and oversight.

Requirement	***The SMA retains authority and responsibility for program operations and oversight.***
Discovery	
Discovery Evidence *(Performance Measure)*	**Number and percent of service plans for participants that were completed within 90 days from the initial assessment.** **Numerator: Number of service plans for participants that were completed within 90 days from the initial assessment**

	Denominator: Number of beneficiaries with person-centered transition plans
Discovery Activity *(Source of Data & sample size)*	100% of all service-plans submitted to MDHHS for approval of 1915(i) services.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS reviews all person-centered service plans to assure they are completed within 90 days of initially assessing the individual for 1915(i) services.
Frequency	Continuous and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDHHS collects, analyzes, and aggregates remediation activities. Reviews are continuous and ongoing for all person-centered service plans approved. Service providers receive reports of the case record reviews and are allowed 30 days to correct any deficiencies noted. MDHHS monitors the implementation of the corrective action to assure quality improvements are realized. Any issues found that jeopardize the health or welfare of the individual will require immediate remediation to the satisfaction of the individual and MDHHS.
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***The SMA retains authority and responsibility for program operations and oversight.***
Discovery	
Discovery Evidence *(Performance Measure)*	**Number and percent of service plans that were approved by MDHHS.** **Numerator: Number of service plans that were approved by MDHHS.** **Denominator: Number of service plans submitted for approval by MDHHS.**
Discovery Activity *(Source of Data & sample size)*	100% of all person-centered service plans submitted to MDHHS for approval
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS reviews all person-centered service plans submitted for approval. MDHHS contacts the transition navigator for any plans submitted that cannot be approved to address the issues identified. The transition navigators have 30 days to remediate all issues.
Frequency	Continuous and Ongoing

Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDHHS collects, analyzes, and aggregates remediation activities. Reviews occur continuously and ongoing for all person-centered service plans submitted for approval. Service providers receive reports of the case record reviews and are allowed 30 days to correct any deficiencies noted. MDHHS monitors the implementation of the corrective action to assure quality improvements are realized. Any issues found that jeopardize the health or welfare of the individual will require immediate remediation to the satisfaction of the individual and MDHHS.
Frequency *(of Analysis and Aggregation)*	Annually

6. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.

Requirement	***The SMA maintains financial accountability through payment of claims for the services that are authorized and furnished to 1915(i) participants by qualified providers.***
Discovery	
Discovery Evidence *(Performance Measure)*	**Number and percent of service plans that supported paid services.** **Numerator: Number of service plans that supported paid services.** **Denominator: Number of service plans approved by MDHHS.**
Discovery Activity *(Source of Data & sample size)*	100% of all service plans
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS assures that all 1915(i) services billed are included on the approved person-centered service plan prior to adjudicating the claims submitted by the provider.
Frequency	Continuous and Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDHHS collects, analyzes, and aggregates remediation activities. Reviews occur continuously and ongoing all person-centered service plans authorized by MDHHS. Service providers are allowed 30 days to correct any deficiencies noted. MDHHS monitors the implementation of the corrective action to assure quality improvements are realized. Claims for services not included on the person-centered service plan will not be authorized for payment.

	Any issues found that jeopardize the health or welfare of the individual will require immediate remediation to the satisfaction of the individual and MDHHS.
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	***The SMA maintains financial accountability through payment of claims for the services that are authorized and furnished to 1915(i) participants by qualified providers.***
Discovery	
Discovery Evidence *(Performance Measure)*	**Number and percent of 1915(i) services claims payments made to providers for 1915(i) services participants with active Medicaid eligibility.** **Numerator: Number of 1915(i) services claims payments made to providers for 1915(i) services participants with active Medicaid.** **Denominator: Total number of 1915(i) services claims payments.**
Discovery Activity *(Source of Data & sample size)*	MDHHS monitors payments made to providers of 1915(i) services to assure payments subject to FFP are only issued for Medicaid-eligible individuals. This will be a 100% sample size.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS has edits in place prior to approving claims to verify that only claims for Medicaid beneficiaries are approved for payment and submitted for FFP.
Frequency	Continuous and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDHHS assures FFP is only requested for claims made for 1915(i) services provided to Medicaid-eligible beneficiaries. MDHHS periodically evaluates all 1915(i) services claims payments subject to FFP to assure the individuals served had Medicaid eligibility on the date of service. Claims adjustments or recoupments are made for any claims for which FFP was requested, but the individual did not have Medicaid eligibility on the date of service.
Frequency *(of Analysis and Aggregation)*	Continuous and ongoing

Requirement	***The SMA maintains financial accountability through payment of claims for the services that are authorized and furnished to 1915(i) participants by qualified providers.***
Discovery	

Discovery Evidence *(Performance Measure)*	**Number and percent of 1915(i) services FFS payments that have been paid at rates approved by MDHHS.** **Numerator: Number of 1915(i) services FFS payments that have been paid at rates approved by MDHHS.** **Denominator: All 1915(i) services FFS payments.**
Discovery Activity *(Source of Data & sample size)*	MDHHS monitors payments made to providers of 1915(i) services to assure payments are only issued for Medicaid-eligible individuals at the MDHHS approved rates. The sample size is 100%.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS uses edits in the MMIS system to assure claims are paid at the rates approved by MDHHS. All claims for services that are above the MDHHS-approved rates are either rejected or adjusted down to the MDHHS approved rate before issuing payment.
Frequency	Continuous and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDHHS assures FFP is only claimed for 1915(i) services provided to Medicaid-eligible individuals. MDHHS periodically evaluates all 1915(i) services claims payments made to assure the individuals served had Medicaid eligibility on the date of service and the claims are paid at the rates approved by MDHHS. Recoupments or adjustments are made as necessary for payments for service provided to all non-eligible individuals and for payments made that are not at the MDHHS approved rate.
Frequency *(of Analysis and Aggregation)*	Continuous and ongoing

7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.

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 case records that indicate a provider took appropriate action when they suspect incidences of abuse, neglect and exploitation have occurred.** **Numerator: Number of case records that indicate a provider took appropriate action when they suspect incidences of abuse, neglect and exploitation.** **Denominator: Number of case records reviewed that indicate an incidence of abuse, neglect or exploitation may have occurred.**

Discovery Activity *(Source of Data & sample size)*	A statistically significant randomly drawn sample of case records to review. Confidence interval is +/- 5%.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS reviews a randomly selected statistically significant sample of all case records for individuals approved for 1915(i) services. This review may include interviews with participants to determine if any potential incidents of abuse, neglect, or exploitation may have occurred, and if so whether those incidents were reported as required.
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDHHS collects, analyzes, and aggregates remediation activities. Reviews occur annually for a statistically significant sample of case records. Service providers receive reports of the case record reviews and are allowed 30 days to develop a corrective action plan for any deficiencies noted. MDHHS monitors the implementation of the corrective action plan to assure quality improvements are realized. Any issues found that jeopardize the health or welfare of the individual require immediate remediation to the satisfaction of the individual and MDHHS.
Frequency *(of Analysis and Aggregation)*	Annually

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 individuals or legal guardians who received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents.** **Numerator: Number of individuals or legal guardians who received information and education in the prior year as documented in the case record.** **Denominator: Number of case records reviewed.**
Discovery Activity *(Source of Data & sample size)*	A statistically significant randomly drawn sample of case records to review. Confidence interval is +/- 5%.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS reviews a randomly selected statistically significant sample of all case records for individuals approved for 1915(i) services. This review may include interviews with participants to determine if any potential incidents of abuse, neglect, or exploitation may have occurred, and if so whether those incidents were reported as required.

Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDHHS collects, analyzes, and aggregates remediation activities. Reviews occur annually for a statistically significant sample of case records. Service providers receive reports of the case record reviews and are allowed 30 days to develop a corrective action plan for any deficiencies noted. MDHHS monitors the implementation of the corrective action plan to assure quality improvements are realized quarterly. Any issues found that jeopardize the health or welfare of the individual require immediate remediation to the satisfaction of the individual and MDHHS.
Frequency *(of Analysis and Aggregation)*	Annually

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 Transition Navigators who have completed required training to identify and report suspected incidents of abuse, neglect, and exploitation, and how to prevent additional incidents.** **Numerator: Number of Transition Navigators who have completed required training to identify and report suspected incidents of abuse, neglect, and exploitation, and how to prevent additional incidents.** **Denominator: All Transition Navigators.**
Discovery Activity *(Source of Data & sample size)*	MDHHS reviews Transition Navigator records to determine whether each Transition Navigator received training on identifying, reporting, and preventing incidents of abuse, neglect, and exploitation. 100% sample size.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	MDHHS reviews agency and individual training records to assure transition navigators are trained on how to identify and report suspected incidents of abuse, neglect or exploitations.
Frequency	Continuous and ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	MDHHS collects, analyzes, and aggregates remediation activities. Reviews of Transition Navigator training will occur annually for all new Transition Navigators. Any Transition Navigator who cannot verify receipt of such training is required to participate in a training and provide verification of participation within 30 days of identifying the issue.

Frequency *(of Analysis and Aggregation)*	Continuous and ongoing

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

MDHHS designed the 1915(i) services quality improvement strategy to assess and improve the quality of services and supports provided through the 1915(i) services option. MDHHS is the Single State Agency responsible for establishing the components of the quality improvement strategy which includes several tools to gather data and measure individual and system performance. Tools utilized include the record review protocol, the participant satisfaction survey, and a Critical Incident Reporting (CIR) system. The system was designed with input from many stakeholders including participants, MI Choice waiver agencies, Centers for Independent Living, PACE organizations, and other interested parties.

An administrative oversight committee remains in place. This committee is comprised of representatives from Area Agencies on Aging, Centers for Independent Living, MDHHS Leadership, PACE, and the Michigan Home and Community Based Services Network. Additionally, the Quality Management Collaborative, which is chaired by HCBS participants, many of whom have transitioned from the nursing facility, is consulted as needed.

Data gathered from the record reviews is used to foster improvements and provide technical assistance at the agency whose records are being reviewed. Annually, this data is compiled to look for systemic trends and areas in need of improvement. The participant satisfaction survey is administered monthly and compiled annually to program participants. This includes those in the process of transitioning, those who have transitioned, and those who closed without transition. Any issues identified through this survey are immediately resolved to the satisfaction of the individual. Data is compiled at the end of each survey cycle and analyzed for trends and areas of improvement.

The administrative oversight committee assist with prioritizing areas of improvement. This group's top priority is to facilitate improvements that will make transitioning easier for the person being served. Everyone on the administrative oversight committee has training in continual quality improvement and this expertise is used to facilitate improvements.

2. Roles and Responsibilities

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

MDHHS staff perform case record reviews. Contracted entities conduct the participant satisfaction surveys. These entities are responsible for providing technical assistance when identified in the performance of their duties. The 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

Quality improvement is continuous and ongoing. MDHHS continuously monitors claims submitted for 1915(i) services, the qualifications of providers, and the satisfaction of individuals served with 1915(i) services. Case record reviews are conducted continuously and ongoing for all records across all providers. Contractors conduct participant satisfaction surveys each month and compiles the data annually.

4. Method for Evaluating Effectiveness of System Changes

MDHHS uses the continual Quality Improvement strategy to facilitate system changes. This focuses on a plan, do, study, act framework for examining the issues, piloting solutions, and studying results before requiring systemic changes. Data is analyzed at least annually 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 is 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
	Effective 10/1/2018, the state uses the same reimbursement rates for HCBS Personal Care as is used for the State Plan Personal Care Option on Item #7 Person Care Services option of Attachment 4.19-B. This service is prior authorized based upon a review of the person-centered service plan and the individual's assessed needs. Michigan uses HCPCS code T1019, Personal care services per 15 minutes for this service. The reimbursement rate depends on whether the provider is an individual or an agency and the participant's county of residence. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of HCBS Personal Care services.
☐	HCBS Adult Day Health
☐	HCBS Habilitation
☐	HCBS Respite Care
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)

✓	**Transition Navigator Case Management Services** Michigan has been providing nursing facility transition services officially since January 1, 2005. Historically, these services have been State funded, or a service available through a HCBS waiver. MDHHS developed rates based upon the historical use and payment for these services, while considering factors such as overhead, non-labor costs, and inflation. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Community Transition services. The Agency's fee schedule rate was set as of 10/1/2018 and is effective for services provided on or after that date. All rates are published on the Agency's website at http://www.michigan.gov/medicaidproviders
✓	**Community Transition services** Michigan has been providing Community Transition services officially since January 1, 2005. Historically, these services have been State funded, or a service available through a HCBS waiver. MDHHS developed rates based upon the historical use and payment for these services, while considering factors such as overhead, non-labor costs, and inflation. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of NFT services. The Agency's fee schedule rate was set as of 10/1/2018, and list revised on 10/1/22, and is effective for services provided on or after that date. All rates are published on the Agency's website at http://www.michigan.gov/medicaidproviders
✓	**Non-Medical (Non-Emergency) Transportation (NENMT)** Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of NENMT services. The Agency's fee schedule rate was set as of 10/1/2018, is revised to correspond with the agency's NEMT fee schedule and is effective for services provided on or after the effective date of any changes. All rates are published on the Agency's website at http://www.michigan.gov/medicaidproviders
✓	**Home Modifications** 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 requires prior authorization of all home modifications and approves reimbursement on a case-by-case basis. For this service to be approved, the transition navigator must submit at least one bid from a qualified provider that describes the modification, how that modification meets the service definition, the cost of building and other materials needed, and the expected labor costs. Smaller items (such as environmental controls) are reimbursed at cost for the item purchased plus the cost of installation. The transition navigator must provide proof of the cost of the item and labor/installation costs prior to approval.