

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations
Disabled and Elderly Health Programs Group
Division of Benefits and Coverage

Mr. Paul Reinhart
Director
Medical Services Administration
Michigan Department of Community Health
Lewis Cass Building
320 South Walnut Street
Lansing, MI 48913

SEP 30 2005

Dear Mr. Reinhart:

I am pleased to inform you that your request for a home and community-based services waiver as authorized under section 1915(c) of the Social Security Act (the Act), for seriously emotionally disturbed (SED) children, has been approved. The waiver has been assigned the Centers for Medicare & Medicaid Services (CMS) control number 0438, which should be used in all future correspondence regarding this waiver.

Specifically, this waiver will provide care in the community for children with SED who, but for the provision of such services, would require a hospital level of care. The waiver is targeted to individuals under age 18 who are chronically mentally ill and would meet the requirements for state psychiatric hospitalization and demonstrate serious functional limitations. Up to 43 youth will be served in each of the first three years of the waiver. Waiver services include family training and support, child therapeutic foster care, respite care, wraparound service facilitation and coordination, community living supports, transitional services, and therapeutic overnight camp.

You requested a waiver of 1902(a)(10)(B) of the Act in order to waive comparability requirements. The State has also requested to waive statewideness, 1902 (a)(1) of the Act, in order to limit waiver services to the counties of Macomb, Livingston, Central Michigan, Clinton-Eaton-Ingham, and Van Buren.

Per e-mail communications received from the State on September 12, 2005, case management responsibilities will be divided appropriately between state entities that oversee mental health, child welfare, family-court-juvenile division, and education. Likewise, this waiver will cover therapeutic foster care services that are beyond any foster care services that are the responsibility of the state entity that oversees child welfare.

Based on the provider qualifications established in the waiver application, any qualified Medicaid provider can serve beneficiaries on this waiver. A waiver participant may utilize the services of a provider contracted with or directly employed by a community mental health center (CMHC), as long as the provider meets all applicable Federal Medicaid requirements, but may also utilize the services of a qualified Medicaid provider outside of the CMHC. If the latter occurs, the qualified Medicaid provider must have an agreement with the Michigan Department of Community Health (MDCH) to bill for services and be audited for financial and quality reviews as with any CMHC. Additionally, appropriate processes must be in place to allow for all qualified Medicaid providers to provide services to this waiver population. For monitoring purposes and renewal of this waiver, CMS will require that the State produce evidence regarding the number of providers that are not affiliated with CMHCs and receive federal financial participation for waiver services.

Based on the information you provided, including discussions and emails, I approve the waiver for a three-year period effective October 1, 2005.

The following estimates of unduplicated recipients and the average per capita cost of waiver services are approved:

Year	Unduplicated Recipients	Factor D
1	43	\$48,823
2	43	\$53,625
3	43	\$53,625

Approval is subject to your agreement to serve no more than the number of individuals indicated above. If Michigan wishes to alter this waiver in any way, an amendment must be submitted for approval. At your request, and with successful demonstration, the waiver can be renewed at the end of the three-year period by providing documentation of satisfactory performance and review by the CMS regional office.

We appreciate the cooperation provided by you and your staff in the continued operation of the home and community-based services waiver program.

Sincerely,



Suzanne Bosstick
Director
Division of Benefits and Coverage

cc: Debbie Milhouse-Slain
Chicago Regional Office



STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

ENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

June 30, 2005

Ms. Cheryl A. Harris
Associate Regional Administrator
Division of Medicaid and Children's Health
Centers for Medicare and Medicaid Services, Region V
Department of Health and Human Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

Dear Ms. Harris:

The State of Michigan would like to request approval of a Home and Community-Based Waiver for children with a serious emotional disturbance (SED). Enclosed you will find an application for your review and approval. After consultation with CMS Health Insurance Specialist, Samantha Wallack, Michigan chose to use the existing waiver application (to which we added an Appendix A: Waiver Administration and Operation and Appendix H: Quality Management Strategy section) of the Draft 1915 (c) Waiver Application Version 3.1, which was not available during the preparation of the renewal application.

Your attention to this request and your continued support is appreciated. If you have any questions, please contact Debbie Milhouse-Slaine, at (517) 241-5757 or by email at Milhouse@Michigan.gov.

Sincerely,

A handwritten signature in black ink that reads "Paul Reinhart".

Paul Reinhart, Director
Medical Services Administration

Enclosures

cc: Samantha Wallack

HOME AND COMMUNITY-BASED SERVICES WAIVER APPLICATION

CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE

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- c. ____ aged and/or disabled
- d. ____ mentally retarded
- e. ____ developmentally disabled
- f. ____ mentally retarded and/or developmentally disabled
- g. X chronically mentally ill
4. A waiver of section 1902(a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):

- a. X Waiver services are limited to the following age groups (specify):

Children under the age of 18

- b. X Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):

The children being served in this waiver will need to meet the current Michigan Department of Community Health (MDCH) contract criteria for the state psychiatric hospital as well as demonstrate serious functional limitations that impair their ability to function in the community. The functional criteria will be identified using the Child and Adolescent Functional Assessment Scale (CAFAS).

- CAFAS score of 90 or greater for children age 12 or younger, or
- CAFAS score of 120 or greater for children age 13 or to 18.

These scores currently identify the top 25th percentile of all children being served by CMHSPs. The average CAFAS score for children who have been in the state psychiatric hospital was 118. This additional requirement will help ensure that only those children with the most serious emotional problems will be served under this waiver.

- c. ____ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.
- d. ____ Other criteria. (Specify):
- e. Not applicable.

5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 in addition to meeting the targeting criteria in items 2 through 4 of this request.
6. This waiver program includes individuals who are eligible under medically needy groups.
- a. Yes b. No
7. A waiver of 1902(a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy.
- a. Yes b. No c. N/A
8. The State will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care referred to in item 2 of this request.
- a. Yes b. No
9. A waiver of the "statewideness" requirements set forth in section 1902(a)(1) of the Act is requested.
- a. Yes b. No
- (Specify): Waiver services will be limited to children in the counties whose approved community-based mental health and developmental disability services provider has an approved SED Waiver plan with the MDCH, has demonstrated strong collaboration with essential community partners, the capacity to provide intensive community-based services, and has the fiscal capacity to manage interagency funding appropriately.
10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.
11. The State requests that the following home and community-based services, as described and defined in Appendix B.1 of this request, be included under this waiver:
- a. Case management
- b. Homemaker
- c. Home health aide services
- d. Personal care services

- e. Respite care
- f. Adult day health
- g. Habilitation
 - Residential habilitation
 - Day habilitation
 - Prevocational services
 - Supported employment services
 - Educational services
- h. Environmental accessibility adaptations
- i. Skilled nursing
- j. Transportation
- k. Specialized medical equipment and supplies
- l. Chore services
- m. Personal Emergency Response Systems
- n. Companion services
- o. Private duty nursing
- p. Family training/support
- q. Attendant care
- r. Adult Residential Care
 - Child therapeutic foster care
 - Assisted living
- s. Extended State plan services (Check all that apply):
 - Physician services
 - Home health care services
 - Physical therapy services
 - Occupational therapy services
 - Speech, hearing and language services
 - Prescribed drugs
 - Other (specify):
- t. Other services (specify):

1. Wraparound facilitation/service coordination
2. Community living support services
3. Therapeutic camp overnight

u. _____ The following services will be provided to individuals with chronic mental illness:

- _____ Day treatment/Partial hospitalization
- _____ Psychosocial rehabilitation
- _____ Clinic services (whether or not furnished in a facility)

12. The state assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.
13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services which are not included in the individual written plan of care.
14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.
15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (Check all that apply):
 - a. When provided as part of respite care in a facility approved by the State that is not a private residence (~~hospital, NF,~~ foster home, or community residential facility).
 - b. _____ Meals furnished as part of a program of adult day health services.
 - c. _____ When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services.

For purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

An explanation of the method by which room and board costs are computed is included in Appendix G-3.

16. The Medicaid agency provides the following assurances to CMS:
- a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:
 1. Adequate standards for all types of providers that furnish services under the waiver (See Appendix B);
 2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (See Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and
 3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.
 - b. The agency will provide for an evaluation (and periodic re-evaluations, at least annually) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and re-evaluations are detailed in Appendix D.
 - c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:
 1. Informed of any feasible alternatives under the waiver; and
 2. Given the choice of either institutional or home and community-based services.
 - d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.
 - e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.
 - f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's

Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.

- g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.
- h. The agency will provide CMS annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by CMS.
- i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502.

- a. Yes b. No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted to CMS at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

- a. Yes b. No

18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

19. An effective date of October 1, 2005 is requested.

20. The State contact person for this request is Debbie Milhouse-Slaine, who can be reached by telephone at (517) 241-5757.

- This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by CMS, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature:

Print Name: Paul Reinhart

Title: Director, Medical Services Administration

Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449. The time required to complete this information collection is estimated to average 160 hours for each new and renewed waiver request and an average of 30 hours for each amendment, including the time to review instructions, searching existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to: CMS, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

APPENDIX A - ADMINISTRATION

Appendix A: Waiver Administration and Operation

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

<input checked="" type="checkbox"/>	The waiver is operated by the State Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (<i>select one</i>):
<input type="checkbox"/>	, the Medical Assistance Unit.
<input checked="" type="checkbox"/>	Michigan Department of Community Health (MDCH) – Mental Health/Substances Abuse Services, another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit. <i>Do not complete item A-2.</i>
<input type="checkbox"/>	The waiver is operated by _____ 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 waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency. <i>Complete item A-2.</i>

2. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the methods that the Medicaid agency uses and the frequency of their use to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements:

Not Applicable

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

<input type="checkbox"/>	Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or waiver operating agency.
<input checked="" type="checkbox"/>	Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the waiver operating agency.

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and specify the type of entity (*check each that applies*):

<input checked="" type="checkbox"/>	<p>Local/Regional non-state public agencies conduct waiver operational and administrative functions at the local or regional level. There is an interagency agreement or memorandum of understanding between the MDCH Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). <i>Specify the nature of these agencies and complete items A-5 and A-6: Pre-paid Inpatient Health Plans (PIHPs) and Community Mental Health Services Programs (CMHSPs)</i></p> <p>MDCH contracts with the CMHSPs as a "local non-state public agency" to conduct operational and administrative functions at the local level.</p>
<input type="checkbox"/>	<p>Local/regional non-governmental non-state entities conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The contract(s) under which private entities conduct waiver operational functions are available through the Medicaid agency or the operating agency (if applicable). <i>Specify the nature of these entities and complete items A-5 and A-6:</i></p>
<input type="checkbox"/>	<p>Not applicable – All waiver operational and administrative functions are performed by a state agency. <i>Do not complete items A-5 and A-6.</i></p>

5. **Responsibility for Assessment of Performance of Local/Regional Non-State Entities.** Specify the State agency that is responsible for assessing the performance of non-state entities that conduct waiver operational and administrative functions:

MDCH

6. **Assessment Methods.** Describe the methods that the State uses and the frequency of their use to assess the performance of non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements:

MDCH is the single State agency that houses the Bureaus of Mental Health / Substance Abuse Services, Medicaid and Public Health. Within the Bureau of Mental Health / Substance Abuse, the MDCH Division of Quality Management and Planning (QMP) conducts annual on-site visits to the PIHP/CMHSPs or other approved community based mental health and developmental disability providers. During these visits, a detailed site review protocol is used to assure quality of services to consumers, compliance with the Michigan Mental Health Code and Administrative Rules, and conformance with all Medicaid requirements. In addition to site reviews completed by the QMP, the MDCH Children's Waiver staff will complete periodic site reviews to the CMHSPs or other approved community based mental health and developmental disability providers. These on-site reviews include home visits of selected Waiver participants and a full clinical review of selected records. The review protocol is specific to assuring compliance with Waiver requirements.

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect conducting the function.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Disseminate information concerning the waiver to potential enrollees	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Assist individuals in waiver enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Manage waiver enrollment against approved limits	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Monitor waiver expenditures against approved levels	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Conduct level of care evaluation activities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Review participant service plans to ensure that waiver requirements are met	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Perform prior authorization of waiver services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Conduct utilization management functions	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Provider recruitment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Execute the Medicaid provider agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Determine waiver payment amounts or rates	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conduct training and technical assistance concerning waiver requirements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

APPENDIX B - SERVICES AND PROVIDER STANDARDS

APPENDIX B-1: DEFINITION OF SERVICES

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2.

a. Case Management

Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

1. Yes 2. No

Case managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified in Appendices C & D of this request.

1. Yes 2. No

Other Service Definition (Specify):

b. Homemaker:

Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

Other Service Definition (Specify):

c. Home Health Aide services:

d. Services defined in 42 CFR 440.70, with the exception that limitations on the amount, duration and scope of such services imposed by the State's approved Medicaid plan shall not be applicable. The amount, duration and scope of these services shall instead be in accordance with the estimates given in Appendix G of this waiver request. Services provided under the waiver shall be in addition to any available under the approved State plan.

Other Service Definition (Specify):

e. _____ Personal care services:

_____ Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bed making, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

1. Services provided by family members (Check one):

_____ Payment will not be made for personal care services furnished by a member of the individual's family.

_____ Personal care providers may be members of the individual's family. Payment will not be made for services furnished to a minor by the child's parent (or step-parent), or to an individual by that person's spouse.

Justification attached. (Check one):

_____ Family members who provide personal care services must meet the same standards as providers who are unrelated to the individual.

_____ Standards for family members providing personal care services differ from those for other providers of this service. The different standards are indicated in Appendix B.

2. Supervision of personal care providers will be furnished by (Check all that apply):

_____ A registered nurse, licensed to practice nursing in the State.

_____ A licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law.

_____ Case managers

_____ Other (Specify):

3. Frequency or intensity of supervision (Check one):

_____ As indicated in the plan of care

_____ Other (Specify):

4. Relationship to State plan services (Check one):

_____ Personal care services are not provided under the approved State plan.

_____ Personal care services are included in the State plan, but with limitations. The waived service will serve as an extension of the State plan service, in accordance with documentation provided in Appendix G of this waiver request.

_____ Personal care services under the State plan differ in service definition or provider type from the services to be offered under the waiver.

_____ Other service definition (Specify):

e. X Respite care:

X Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

_____ Other service definition (Specify):

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite care will be provided in the following location(s) (Check all that apply):

X Individual's home or place of residence, family friend's home in the community

X Foster home

_____ Medicaid certified Hospital

_____ Medicaid certified NF

_____ Medicaid certified ICF/MR

X Group home

_____ Licensed respite care facility

_____ Other service definition (Specify):

f. _____ Adult day health:

_____ Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services. (Check one):

1. _____ Yes 2. _____ No

_____ Other service definition (Specify):

Qualifications of the providers of adult day health services are contained in Appendix B-2.

g. _____ Habilitation:

_____ Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

_____ Residential habilitation: assistance with acquisition, retention, or improvement in skills related to activities of daily living such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Documentation which shows that Medicaid payment does not cover these components is attached to Appendix G.

_____ Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills which take place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

_____ Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs). Prevocational services are available only to individuals who have previously been discharged from a SNF, ICF, NF or ICF/MR.

Check one:

_____ Individuals will not be compensated for prevocational services.

_____ When compensated, individuals are paid at less than 50 percent of the minimum wage.

Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that:

- a. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
- b. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

_____ Educational services, which consist of special education and related services as defined in sections (15) and (17) of the Individuals with Disabilities Education Act, to the extent to which they are not available under a program funded by IDEA. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

_____ Supported employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for vocational training that is not directly related to an individual's supported employment program.

Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

1. Yes 2. No

Other service definition (Specify):

The State requests the authority to provide the following additional services, not specified in the statute. The State assures that each service is cost-effective and necessary to prevent institutionalization. The cost neutrality of each service is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

h. Environmental accessibility adaptations:

Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc.

Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

_____ Other service definition (Specify):

i. _____ Skilled nursing:

_____ Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

_____ Other service definition (Specify):

j. _____ Transportation:

_____ Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered 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) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

_____ Other service definition (Specify):

k. _____ Specialized Medical Equipment and Supplies:

_____ Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

_____ Other service definition (Specify):

_____ Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and

gress. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

_____ Other service definition (Specify):

l. _____ Personal Emergency Response Systems (PERS)

_____ PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified in Appendix B-2. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

_____ Other service definition (Specify):

m. _____ Adult companion services:

_____ Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

_____ Other service definition (Specify):

n. _____ Private duty nursing:

_____ Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to an individual at home.

_____ Other service definition (Specify):

o. X Family training/support:

 X Training and counseling services for the families of individuals served on this waiver. For purposes of this service, "family" is defined as the person(s) who live with or provide care to a person served on the waiver, and may include a parent and/or siblings or

the foster parent(s) for a child in Therapeutic Child Foster Care. Training includes instruction about treatment regimens and behavioral plans specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home.

It is also a counseling service directed to the family and designed to improve and develop the family's skills in dealing with the life circumstances of parenting a child with special needs and help the child remain at home. All family training must be included in the child's individual plan of care and must be provided on a face-to-face basis.

p. _____ Attendant care services:

_____ Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity.

Supervision (Check all that apply):

_____ Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the individual's written plan of care.

_____ Supervision may be furnished directly by the individual, when the person has been trained to perform this function, and when the safety and efficacy of consumer-provided supervision has been certified in writing by a registered nurse or otherwise as provided in State law. This certification must be based on direct observation of the consumer and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained in the consumer's individual plan of care.

_____ Other supervisory arrangements (Specify):

_____ Other service definition (Specify):

q. X ~~Child Adult Residential Care~~ (Check all that apply):

X Child Therapeutic Foster Care (CTFC) is an evidence-based practice. It provides an intensive therapeutic living environment for a child with a behavior disorder. Important components of Child Therapeutic foster care include: intensive parental supervision, positive adult –youth relationship, reduced contact with other behaviorally disorder children and family behavior

management skills. CTFC seeks to change the negative trajectory of a child's behavior by improving their social adjustment, family adjustment and peer group. CTFC attempts to decrease negative behavior and increase appropriate behavior and build pro-social skills. Foster parents, teachers, therapists and other adults act as change agents for the child. They all contribute to the treatment of the child and the preparation of his/her family for returning home. Foster parents are specially recruited, behaviorally trained and supervised. The total number of individuals (including persons served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed 1. In addition to being licensed all therapeutic foster care programs under this waiver will be pre-enrolled by MDCH to ensure they meet the requirements set forth in this document. Separate payment will not be made for homemaker or chore services, or for community living services provided by the foster parents, or for respite care furnished for the foster care parents to a child receiving Therapeutic Foster Care services, since these services are integral to and inherent in the provision of Child Therapeutic Foster Care. The chart on page 23 compares Child Therapeutic Foster Care to regular foster care.

Comparison Chart Therapeutic Foster Care Compared to Regular Foster Care

Therapeutic Foster Care	Regular Foster care
1) Therapeutic foster care is a cost effective alternative to hospitalization.	1) Regular Foster care is not intensive enough to serve as an alternative to hospitalization.
2) Foster families are specially recruited, behaviorally trained and supervised.	2) Foster families are recruited but are not always given specialized behavioral training or supervision.
3) A structured and therapeutic living environment is provided.	3) The foster family home is not required to be structured or therapeutic.
4) In conjunction with the foster care placement family therapy is provided for the youth's biological or adoptive family.	4) Family Therapy may or may not be provided to the youth's biological or adoptive family.
5) The foster parents are trained to use a structured behavioral system	5) The foster parents do not necessarily use a structured behavioral program.
6) Home visits are closely supervised and conducted throughout the youth's placement in the foster home.	6) Home visits are not closely supervised
7) Frequent contact is maintained between foster home, youth's teacher, foster care workers, and therapists. School attendance and performance is monitored daily.	7) Contact with various individuals can be sporadic
8) Only one foster youth may be placed in a home.	8) Many foster youth may be placed in a home.
9) Families must complete 20 hours of pre service training based on a learning theory and are taught to implement a daily behavioral management program and provided ongoing training.	9) Families receive minimal training
10) Youth participate in therapy (provided by qualified mental health professionals) focused on developing effective problem solving, social, emotional regulation skills.	10) Youth may or may not participate in therapy

_____ Assisted living: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, in conjunction with residing in the facility. This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

Assisted living services may also include (Check all that apply):

- _____ Home health care
- _____ Physical therapy
- _____ Occupational therapy
- _____ Speech therapy
- _____ Medication administration

_____ Intermittent skilled nursing services

_____ Transportation specified in the plan of care

_____ Periodic nursing evaluations

_____ Other (Specify)

However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24- hour care or supervision. FFP is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility

_____ Other service definition (Specify):

Payments for adult residential care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for adult residential care services does not include payments made, directly or indirectly, to members of the consumer's immediate family. The methodology by which payments are calculated and made is described in Appendix G.

r. Other waiver services which are cost-effective and necessary to prevent institutionalization (Specify):

 X Wraparound Service Facilitation and Coordination for Children and Adolescents is a highly individualized planning process performed by specialized wraparound facilitators employed by the CMHSP, or other approved community-based mental health and developmental disability services provider, or its provider network who, using the Wraparound model, coordinate the planning for, and delivery of, services and supports that are medically necessary for the child. The planning process identifies the child's strengths, needs, strategies and outcomes. Wraparound utilizes a Child and Family Team with team members determined by the family, often representing multiple agencies and informal supports. The Child and Family Team create a highly individualized plan of service for the child that consists of mental health specialty treatment, services and supports covered by the Medicaid mental health State plan or the waiver. The plan may also consist of other non-mental health services that are secured from and funded by other agencies in the community. The Wraparound plan is the result of a collaborative team planning process that focuses on the unique strengths, values, and preferences of the child and family and is developed in partnership with other community agencies. The Community Team that consists of parents, agency representatives, and other relevant community members oversees wraparound.

Coverage includes:

- Planning and/or facilitating planning using the Wraparound process including at least one monthly face-to-face intervention.
- Developing an individualized plan of service utilizing the Wraparound process.
- Linking to, coordinating with, follow-up of, and advocacy with, and/or monitoring of waiver and other state plan with the Wraparound Community Team and other community services and supports.
- Brokering of providers of services with the assistance of the Wraparound Community Team.
- Assistance with access to other entitlements.
- Coordination with the Medicaid health plan, or other health care providers.

Coverage excludes:

- Case management that is the responsibility of child welfare, juvenile justice, or foster care services
- Case management for legal or court-ordered non-medically necessary services
- Direct service provision
- Services and supports that are the responsibility of other agencies on the Community Team

X Community Living Supports: are used to increase or maintain personal self-sufficiency, thus facilitating an individual's achievement of his/her goals of community inclusion and remaining in their home. The supports may be provided in the participant's residence or in community settings (including but not limited to libraries, city pools, camps, etc.).

Community Living Services provides assistance to the family in the care of their child, while facilitating the child's independence and integration into the community. The supports, as identified in the POS, are provided in the child's home and may be provided in community settings when integration into the community is an identified goal. Skills related to activities of daily living, such as personal hygiene, household chores, and socialization may be included. It may also promote communication, and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child enabling the child to attain or maintain their maximum potential. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings.

Behavioral Coverage includes:

- A. Assistance with skill development related to:
- activities of daily living such as personal hygiene

- household chores
 - socialization
 - improve communication, and relationship-building skills
 - participation in leisure and community activities.
- B. Staff assistance, support and/or training with such activities as:
- behavioral interventions
 - non-medical care (not requiring nurse or physician intervention)
 - transportation (excluding to and from medical appointments) from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence
 - participation in regular community activities and recreation opportunities (attending classes, movies, concerts and events in a park; volunteering; etc.)
 - assist the family in relating to, and caring for their child
 - attendance at medical appointments
 - acquiring or procuring goods other than those listed under shopping, and nonmedical services
- C. Reminding, observing, rewarding and monitoring of pro-social behaviors
- D. Medication administration
- E. Staff assistance with preserving the health and safety of the individual in order that he/she may reside or be supported in the most integrated, independent community setting.

X Transitional services: A one-time-only expense to assist beneficiaries returning to their home and community while the family is in the process of securing other benefits (e.g. SSI) or resources (e.g., governmental rental assistance and/or home ownership programs) that may be available to assume these obligations and provide needed assistance.

Additional criteria for using Transitional services:

- The beneficiary must have in his/her family-centered plan of services a goal to return to his/her home and community; and
- Documentation of the family's control (i.e., signed lease, rental agreement, deed) of their living arrangement in the family-centered plan of service; and

- Documentation of efforts (e.g., the family is on a waiting list) under way to secure other benefits, such as SSI, or public programs (e.g., governmental rental assistance, community housing initiatives and/or home ownership programs) so when these become available, they will assume these obligations and provide the needed assistance.

Coverage includes:

- Assistance with utilities, insurance, and moving expenses where such expenses would pose a barrier to a successful transition to the beneficiary's family home
- Interim assistance with utilities, insurance, or living expenses when the beneficiary's family already living in an independent setting experiences a temporary reduction or termination of their own or other community resources
- Home maintenance when, without a repair to the home or replacement of a necessary appliance, the individual would be unable to move there, or if already living there, would be forced to leave for health and safety reasons.

All services provided must be in accordance with applicable state or local building codes. Standards of value purchasing must be followed. The home maintenance must be the most reasonable alternative, based on the results of a review of all options. The existing structure must have the capability to accept and support the proposed changes. The infrastructure of the home involved must be in compliance with any applicable local codes. The home maintenance involved shall exclude costs for improvements exclusively required to meet local building codes. The home maintenance must incorporate reasonable and necessary construction standards, excluding cosmetic improvements. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values.

Coverage excludes those adaptations or improvements to the home that are

- of general utility or are cosmetic,
- are considered to be standard housing obligations of the beneficiary's family
- are not of direct medical or remedial benefit to the child,
- are for on-going housing costs
- costs for room and board that are not directly associated with transition arrangements while securing other benefits.

Requests for transitional services must be prior authorized by the CMHSP following denial by all other applicable resources (e.g., private insurance, Medicaid). All services shall be provided in accordance with applicable state or local building codes.

X Therapeutic Overnight Camp – A group recreational and skill building service in a camp setting aimed at meeting a goal(s) detailed in the beneficiary's

individualized plan of care. A session can be one or more days and nights of camp. Room and Board will also be excluded from the cost of this service.

Additional Criteria:

- Camps are licensed by the Department of Human Services
- The child's plan of service includes the overnight camp
- The staff of the camp are trained in working with children with serious emotional disturbance

Coverage Includes

- Camp fees, including enrollment and other fees
- Transportation to and from the camp
- Additional costs for staff with specialized training with this population

Coverage Excludes

- Room and board for the camp.

s. _____ Extended State plan services:

The following services, available through the approved State plan, will be provided, except that the limitations on amount, duration and scope specified in the plan will not apply. Services will be as defined and described in the approved State plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State plan until the plan limitations have been reached. Documentation of the extent of services and cost-effectiveness are demonstrated in Appendix G. (Check all that apply):

- _____ Physician services
- _____ Home health care services
- _____ Physical therapy services
- _____ Occupational therapy services
- _____ Speech, hearing and language services
- _____ Prescribed drugs
- _____ Other State plan services (Specify):

t. _____ Services for individuals with chronic mental illness, consisting of (Check one):

- _____ Day treatment or other partial hospitalization services (Check one):
- _____ Services that are necessary for the diagnosis or treatment of the individual's mental illness. These services consist of the following elements:

- a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),
- b. occupational therapy, requiring the skills of a qualified occupational therapist,
- c. services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness,
- d. drugs and biologicals furnished for therapeutic purposes,
- e. individual activity therapies that are not primarily recreational or diversionary,
- f. family counseling (the primary purpose of which is treatment of the individual's condition),
- g. training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and
- h. diagnostic services

Meals and transportation are excluded from reimbursement under this service. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

_____ Other service definition (Specify):

_____ Psychosocial rehabilitation services (Check one):

_____ Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:

- a. restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);
- b. social skills training in appropriate use of community services;
- c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and
- d. telephone monitoring and counseling services.

The following are specifically excluded from Medicaid payment for psychosocial rehabilitation services:

- a. vocational services,

b. prevocational services,

c. supported employment services, and

d. room and board. Other service definition (Specify):

Clinic services (whether or not furnished in a facility) are services defined in 42 CFR 440.90.

Check one:

This service is furnished only on the premises of a clinic.

Clinic services provided under this waiver may be furnished outside the clinic facility. Services may be furnished in the following locations (Specify):

APPENDIX B-2

PROVIDER QUALIFICATIONS

A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached.

Service	Definition	Provider	License	Cert.	Other Standard
Wraparound Facilitation/ Community Support	A highly individualized planning process performed by specialized wraparound facilitators employed by the CMHSP, or an approved community-based mental health and developmental disability services provider, or its provider network who, using the Wraparound model, coordinate the planning for, and delivery of, services and supports that are medically necessary for the child. Wraparound utilizes a Child and Family Team with team members determined by the family. The plan may also consist State plan and waiver services and other non mental health services that are secured from and funded by other agencies in the community. The Wrap-around plan is the result of a collaborative team planning process that focuses on the unique strengths, values, and preferences of the child and family and is developed in partnership with other community agencies.	Approved community-based mental health and developmental disability services provider, such as a CMHSP	N/A	Accreditation by one of the DCH-approved accreditation organizations, provision of a continuum of care, including crisis intervention and participation in a system of care including both a governing coalition and service delivery endorsing the values and principles of a system of care. Provider entities will maintain documentation that individual Wraparound Facilitators meet "other standards" and training requirements as described in the provider qualification chart.	Wraparound Facilitators must complete DCH required training. A bachelor's degree in human services or a related field; or other approved work/personal experience in providing direct services or linking of services for children with SED. Wraparound facilitators must have a criminal history screen, a screen with state and local Child Protection Agency registries. They must be supervised by an individual who meets criteria as a qualified mental health professional (QMHP), who has completed DCH required training.
Respite Care	Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care	Approved community-based mental health and developmental disability services provider, such as a CMHSP		See endnote a	MA enrolled; See endnote b

Service	Definition	Provider	License	Cert.	Other Standard
Respite Care -- Continued		Aide-level staff* Foster Care Provider	MCL 722.122(Children), [Foster Care Licensure]		As Specified in the POS; see endnote c Services may be provided in or out-of-home - as specified in the POS
Community Living Services / Supports (CLS)	CLS: are used to increase or maintain personal self-sufficiency, thus facilitating an individual's achievement of his/her goals of community inclusion and participation, independence or productivity. The supports may be provided to the participant/family in their residence or in community settings.	Approved community-based mental health and developmental disability services provider, such as a CMHSP Aide-level staff*		See endnote a	MA enrolled; See endnote b As Specified in the POS; see endnote c
Family Home Care Training	Training and counseling services for the families of individuals served on this waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, and/or siblings. "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home. It is also a counseling service directed to the family and designed to improve and develop the family's skills in dealing with the life	Approved community-based mental health and developmental disability services provider, such as a CMHSP Psychologist Masters Level Social Worker	Current license under part 18 of Michigan PA 368 of 1978, as amended	See Endnote a Current certification of registration under Michigan PA 352 of 1972, as amended	MA enrolled; See endnote b

Service	Definition	Provider	License	Cert.	Other Standard
	<p>circumstances of parenting a child with special needs. All family training must be included in the child's individual plan of care and must be provided on a face-to-face basis.</p>	QMHP			CFR 483.430
Child Therapeutic Foster Care	<p>Child Therapeutic Foster Care (CTFC) is an evidence-based practice. It provides an intensive therapeutic living environment for a child with a behavior disorder. Important components of CTFC include: intensive parental supervision, positive adult-youth relationship, reduced contact with other children w/ behavior disordered, and family behavior management skills. CTFC seeks to change the negative trajectory of a child's behavior by improving social adjustment, family adjustment and peer group relationships. CTFC attempts to decrease negative behavior and increase appropriate behavior and build pro-social skills. Foster parents, teachers, therapists and other adults act as change agents for the child. They all contribute to the treatment of the child and the preparation of his/her family for returning home. Foster parents are specially recruited, behaviorally trained and supervised by qualified mental health professionals. The total number of individuals (including persons served in the waiver) living in the home, unrelated to the principal care provider, cannot exceed 1. Separate payment will not be made for homemaker or chore services, community living services provided by the foster parents, respite care furnished for the foster care parents,</p>	Foster Care Provider See endnote d	MCL 722.122 [Foster Care Licensure]	DHS certified	As specified in the POS

Service	Definition	Provider	License	Cert.	Other Standard
Therapeutic Overnight Camp	as these services are inherent in the provision of CTFC. Community living services not provided by foster parents, but by other trained staff will be provided and paid for separately. Other waiver services such as wraparound and family home care training may also be provided as well as other medically necessary state plan services				
Transition Services	A group recreational and skill building service in a camp setting aimed at meeting a goal(s) detailed in the beneficiary's individualized plan of care. Assistance to the family with one-time-only expenses to assist beneficiaries to return to, or remain in, their home, while the family is in the process of securing other benefits (e.g. SSI) or public programs (e.g., governmental rental assistance and/or home ownership programs) that may be available to assume these obligations and provide needed assistance	Camp counselors and other camp staff Licensed Builder Utility Companies	Licensed camps MCL 339.601(1) MCL 339.601.2401 MCL 339.601.2404 Licensed Utility Companies	DHS Certified	As specified in the POS As specified in the POS As specified in the POS

Endnotes

- a. Must meet certification requirements as specified in Section 232a of the Michigan Mental Health Code, Public Act 258 of 1974, as amended, and the Administrative Rules applicable thereto.
- b. Must be able to provide, either directly or under contract, a comprehensive array of services, as specified in Section 206 of the Michigan Mental Health Code, Public Act 258 of 1974, as amended, and the Administrative Rules applicable thereto.
- c. Trained staff performing respite care and CLS must, in addition to the specific training, supervision, and standards for each support/service, be:
 - Responsible adults at least 18 years of age
 - Free from communicable disease
 - Able to read and follow written plans of service/supports as well as participant-specific emergency procedures
 - Able to write legible progress and/or status notes
 - In "good standing" with the law (i.e., not a fugitive from justice, a convicted felon or illegal alien)
 - Successfully completed Recipient Rights Training
 - Able to perform basic first aid and emergency procedures.
- d. In addition to "therapeutic foster care", these children are eligible to receive all other SED waiver services and Medicaid State Plan services, as medically necessary and as specified in the POS. Family Home Care Training may be provided to the parent(s) providing therapeutic child foster.

Providers of all services must meet qualifications as specified in this appendix and by Medicaid. Separate payment will not be made for homemaker or chore services, community living services provided by the foster parents, or respite care furnished for the foster care parents, as these services are integral to and inherent in the provision of Child Therapeutic Foster Care. In addition the Child Therapeutic Foster Care per diem will not be paid for the time a child attends Therapeutic Overnight Camp sessions.

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State of Michigan assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

The State of Michigan assures that each individual found eligible for the waiver will be given free choice of all qualified providers for each service included in his or her written plan of care.

APPENDIX B-3

KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

KEYS AMENDMENT ASSURANCE:

The State of Michigan assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

- Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.
- A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.

APPENDIX C-Eligibility and Post-Eligibility

**APPENDIX C-1--Eligibility
MEDICAID ELIGIBILITY GROUPS SERVED**

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. **(Check all that apply.)**

1. Low income families with children as described in section 1931 of the Social Security Act.
2. SSI recipients (SSI Criteria States and 1634 States).
3. Aged, blind or disabled in 209(b) States who are eligible under 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).
4. Optional State supplement recipients
5. Optional categorically needy aged and disabled who have income at (Check one):
 - a. 100% of the Federal poverty level (FPL)
 - b. % Percent of FPL which is lower than 100%.
6. The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

- a. Yes b. No

Check one:

- a. The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or
- b. Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and

community-based services in order to remain in the community are included in this waiver: (check all that apply):

- (1) A special income level equal to:
 300% of the SSI Federal benefit (FBR)
 % of FBR, which is lower than 300% (42 CFR 435.236)
\$ which is lower than 300%
- (2) Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)
- (3) provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435,324.)
- (4) Medically needy without spend down in 209(b) States. (42 CFR 435.330)
- (5) Aged and disabled who have income at:
a. 100% of the FPL
b. % which is lower than 100%.
- (6) Other (Include statutory reference only to reflect additional groups included under the State plan.)

7. Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8. Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

APPENDIX C-2--POST-ELIGIBILITY

GENERAL INSTRUCTIONS

ALL home and community-based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under 435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community (435.217). For individuals whose eligibility is not determined under the spousal rules (1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

- OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR 435.726 and 435.735 just as it does for other individuals found eligible under 435.217 or;
- OPTION 2: it may use the spousal post-eligibility rules under 1924.

REGULAR POST-ELIGIBILITY RULES--435.726 and 435.735

- o The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.
- o If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.
- o If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.
- o If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC need standard for a family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

SPOUSAL POST-ELIGIBILITY--1924

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of 1924 of the Act (protection against spousal impoverishment) instead of the post-eligibility rules under 42 CFR 435.726 and 435.735. The 1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735. Spousal impoverishment post-eligibility rules can only be used if the State is using spousal impoverishment eligibility rules.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in 1902(q)(1)" for the needs of the institutionalized individual. This is an allowance which is reasonable in amount for clothing and other personal needs of the individual . . . while in an institution." For institutionalized individuals this amount could be as low as \$30 per month. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. The \$30 PNA is not a sufficient amount for these needs when the individual is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the 1924 spousal impoverishment post-eligibility rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community.

POST ELIGIBILITY REGULAR POST ELIGIBILITY

1. XX **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

A. 435.726--States which **do not use more restrictive** eligibility requirements than SSI.

a. Allowances for the needs of the

1. individual: (Check one):

A. XX The following standard included under the State plan (check one):

(1) XX SSI

(2) _____ Medically needy

(3) _____ The special income level for the institutionalized

(4) _____ The following percent of the Federal poverty level): %

(5) _____ Other (specify):

B. _____ The following dollar amount:

\$ _____ * If this amount changes, this item will be revised.

C. _____ The following formula is used to determine the needs allowance:

Note: If the amount protected for waiver recipients in item 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2. and 3.** following.

2. spouse only (check one):

A. _____ SSI standard

B. _____ Optional State supplement standard

C. _____ Medically needy income standard

D. _____ The following dollar amount:

\$ _____ *

* If this amount changes, this item will be revised.

E. _____ The following percentage of the following standard that is not greater than the standards above: % of standard.

F. _____ The amount is determined using the following formula:

G. Not applicable (N/A)

3. Family (check one):

A. _____ AFDC need standard

B. _____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C. The following dollar amount:

\$ _____ *

*if this amount changes, this item will be revised.

D. _____ The following percentage of the following standard that is not greater than the standards above: % of standard.

E. _____ The amount is determined using the following formula:

F. _____ Other

G. Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

**POST-ELIGIBILITY
REGULAR POST ELIGIBILITY**

1.(b) _____ 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

B. 42 CFR 435.735--States using more restrictive requirements than SSI.

(a) Allowances for the needs of the

1. individual: (check one):

A. _____ The following standard included under the State plan (check one):

(1) _____ SSI

(2) _____ Medically needy

(3) _____ The special income level for the institutionalized

(4) _____ The following percentage of the Federal
poverty level: %

(5) _____ Other (specify):

B. _____ The following dollar amount:

\$ _____ *

* If this amount changes, this item will be revised.

C. The following formula is used to determine the amount:

Note: If the amount protected for waiver recipients in 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 435.217, **enter NA in items 2. and 3.** following.

2. spouse only (check one):

A. _____ The following standard under 42 CFR 435.121:

B. _____ The medically needy income standard

C. _____ The following dollar amount:

\$ _____ *

* If this amount changes, this item will be revised.

D. _____ The following percentage of the following standard that is not greater than the standards above: % of

E. _____ The following formula is used to determine the amount:

F. _____ Not applicable (N/A)

3. family (check one):

A. _____ AFDC need standard

B. _____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C. _____ The following dollar amount:

\$ _____ *

• If this amount changes, this item will be revised.

•

D. _____ The following percentage of the following standard that is not greater than the standards above: % of standard.

E. _____ The following formula is used to determine the amount:

F. _____ Other

G. _____ Not applicable (N/A)

c. Medical and remedial care expenses specified in 42 CFR 435.735.

**POST ELIGIBILITY
SPOUSAL POST ELIGIBILITY**

2. _____ The State uses the post-eligibility rules of 1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of home and community-based care if it determines the individual's eligibility under 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual: (check one)

(a) _____ SSI Standard

(b) _____ Medically Needy Standard

(c) _____ The special income level for the institutionalized

(d) _____ The following percent of the Federal poverty level: %

(e) _____ The following dollar amount

\$ _____ **

**If this amount changes, this item will be revised.

(f) _____ The following formula is used to determine the needs allowance:

(g) _____ Other (specify):

If this amount is different from the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community.

APPENDIX D - ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1

a. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in the Executive Summary of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (check all that apply):

_____ Discharge planning team

_____ Physician (MD or DO)

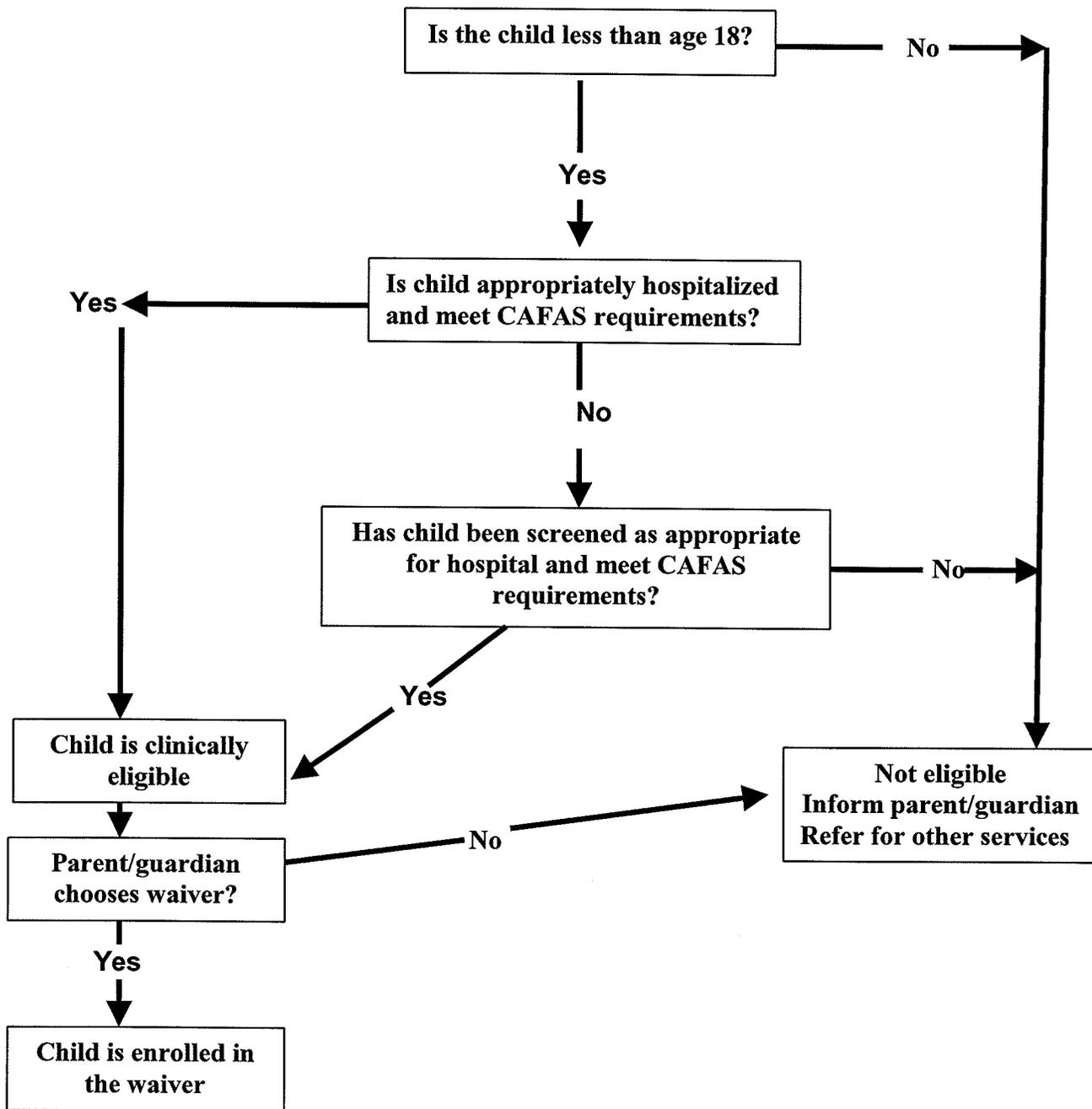
_____ Registered nurse, licensed in the state

Child Mental Health Professional as defined in Rule 330.2105(b) of the Michigan Mental Health Code Administrative Rules for Children's Diagnostic and Treatment Service. The evaluator must also be trained in the CAFAS.

_____ Qualified mental retardation professional, as defined in 42 CFR 483.430(a)

_____ Other (specify):

Waiver Clinical Eligibility Process



APPENDIX D-2

a. RE-EVALUATIONS OF LEVEL OF CARE

Re-evaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (specify):

_____ Every 3 months

_____ Every 6 months

X Every 12 months

_____ Other (specify):

b. QUALIFICATIONS OF PERSONS PERFORMING RE-EVALUATIONS

Check one:

X The educational/professional qualifications of person(s) performing re-evaluations of level of care are the same as those for persons performing initial evaluations.

_____ The educational/professional qualifications of persons performing re-evaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for all individuals performing re-evaluations of level of care (specify):

_____ Physician (MD or DO)

_____ Registered nurse, licensed in the state

_____ Certified social worker

_____ Qualified mental retardation professional, as defined in 42 CFR 483.430(a)

_____ Other (specify):

c. PROCEDURES TO ENSURE TIMELY RE-EVALUATIONS

The state will employ the following procedures to ensure timely re-evaluations of level of care (check below):

X "Tickler" file

_____ Edits in computer system

X Component part of case management

_____ Other (specify):

APPENDIX D-3

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (check all that apply):

_____ By the Medicaid Agency in its central office

_____ By the Medicaid Agency in district/local offices

X By the agency designated in Appendix A as having primary authority for the daily operation of the waiver program

X By the case managers in the beneficiary's case file or other approved community-based mental health and developmental disability provider at the CMHSP

_____ By the persons or agencies designated as responsible for the performance of evaluations and reevaluations

_____ By service providers

_____ Other (specify):

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION/ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and re-evaluation and screening procedures for individuals need for a level of care indicated in the Executive Summary of this request is attached to this Appendix.

For persons diverted rather than deinstitutionalized, the state's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in the Executive Summary of this request.

Check one:

X The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.

_____ The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

APPENDIX D-4

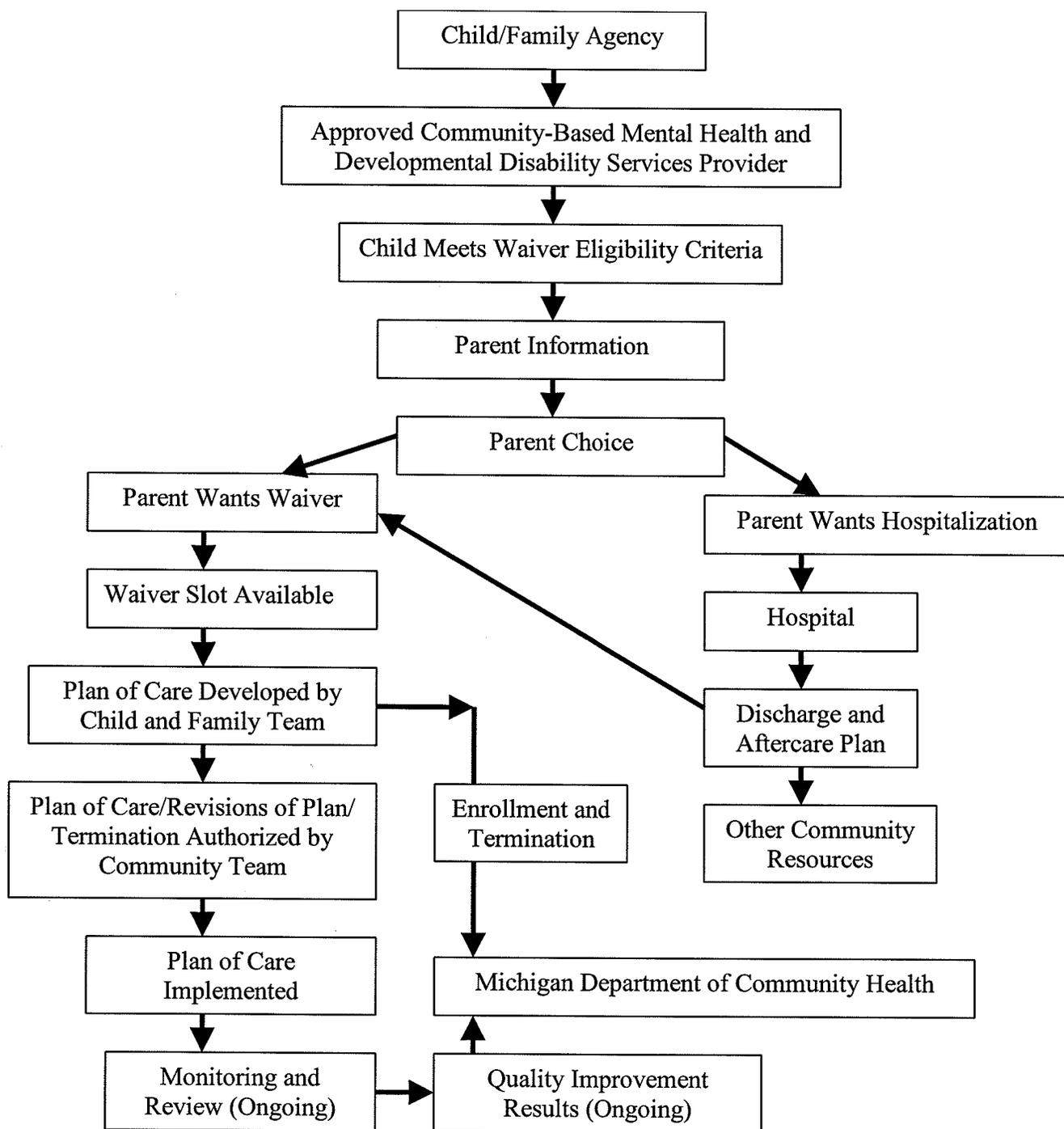
FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care indicated in the Executive Summary of this request, the individual or his or her legal representative will be:
 - a. Informed of any feasible alternatives under the waiver; and
 - b. Given the choice of either institutional or home and community-based services.
 2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in the Executive Summary of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.
 3. The following are attached to this Appendix:
 - a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing:
 - b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver.
 - c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services; and
 - d. A description of how the individual (or legal representatives) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.
- a. FREEDOM OF CHOICE DOCUMENT

Specify where copies of this form are maintained: The waiver certification form, which documents freedom of choice for waiver services over psychiatric hospitalization, and the choice of providers is maintained in the child's case file at the provider agency and in the Department of Community Health Central Office files. The issue of choice is discussed with the family prior to approval for waiver services and the implementation of the POS.

A description of the MDCH Appeal process can be found at the MDCH website: <http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>. This is taken from the Michigan Administrative Hearing Policy and Procedures, found in the Michigan Mental Health Codes and in the provider contracts. MDCH tracks all administrative hearing decisions, including when an LOC change occurs. MDCH will provide a summary of this analysis to CMS in the quality assurance impact component of the annual CMS 372 submission.

Referral and Service Process for Waiver



HOME AND COMMUNITY-BASED SERVICES
FOR CHILDREN WITH A SERIOUS EMOTIONAL DISTURBANCE

FAMILY CHOICE ASSURANCE DOCUMENT

Child Name

Family Name

I understand that my child is eligible for HCBS-SED Waiver services as an alternative to services in a state mental health hospital.

I have been informed that my child may receive services in my home and/or community. I have been informed about the home and community-based services waiver program for children with serious emotional disturbance which may be used as an alternative to pursuing admission to a state mental health hospital.

My signature below indicates I have been informed of the options available for my child; and I am aware of my choice of qualified service providers.

My choice is to: (check one)

1. Keep my child at home with supports from the home and community-based services waiver program and request a Wraparound facilitator work with me to develop an individual plan of service for my child.

2. Pursue state mental health hospitalization for my child.

3. Refuse all services

Signature:

Parent/Legal Guardian

Date

Witness

Date

Approved Community-Based Mental Health and Developmental Disability Services Provider

APPENDIX E - PLAN OF CARE

APPENDIX E-1

a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the individual plans of care:

Registered nurse, licensed to practice in the State

Licensed practical or vocational nurse, acting within the scope of practice under State law

Physician (M.D. or D.O.) licensed to practice in the State

Social Worker (qualifications attached to this Appendix)

Case Manager (wraparound facilitator)

Other (specify):

The child, youth and family members are essential to this process. Additionally, the other members of the plan of care team are determined through the person-centered planning/family-centered practice process and are based on the needs and preference of the child and family.

1. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.

At the Medicaid agency central office

At the Medicaid agency county/regional offices

By case managers (wraparound facilitator) in the child's case file

By the agency specified in Appendix A

By consumers

Other (specify):

3. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

Every 3 months

Every 6 months

Every 12 months

Other (specify):

APPENDIX E-2

a. MEDICAID AGENCY APPROVAL

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency:

The MDCH Division of Quality Management and Planning (QMP) currently conducts annual on-site visits to the PIHP/CMHSPs or other approved community-based mental health and developmental disability services providers. Because the SED waiver is a fee-for-service program, day to day operations are performed by the approved community-based mental health and developmental disability services providers and are not the responsibility of the PIHPs. During the QMP on-site visits, samples of plans of care (POS) are reviewed. The MDCH SED Waiver staff also will complete periodic site reviews of the approved community-based mental health and developmental disability services providers. During these site reviews, the plans of care are reviewed.

b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.
2. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix.

No standardized form is required. The plan of care will contain information identified in b.1. above.

The state employs the following planning process for supports and services under the home and community-based waiver. The Michigan Mental Health Code establishes the right for all individuals to have their individual plan of services developed through a person-centered planning (PCP) process regardless of age, disability, or residential setting. PCP is a highly individualized process designed to plan and support the individual receiving services by building upon the individual's capacity to engage in activities that promote community life and honors the individual's preferences, choices, and abilities. The PCP process involves families, friends, and professionals as the individual desires or requires. Health and safety needs are addressed in the POS with supports listed to accommodate those needs. The MDCH has advocated and supported a family-centered planning (FCP) approach to service delivery to children, youth, and their families. This approach recognizes the importance of the family and the fact that supports and services impact the entire family. Therefore, in the case of minors, the child is the focus of the services planning, and family members are integral to the planning process and its success. Along with the health and safety needs of the child, the wants and needs of the child/family are considered in the development of the POS. Each participant will have an individual plan of care that specifies the supports and services that the child will receive.

Each child will have a Wraparound facilitator who is responsible for assisting the child/family in planning and organizing their Wraparound Community Team and in developing their plan of service (POS). The Wraparound facilitator will be responsible for monitoring both supports and

service delivery, as well as monitoring the health and safety of the child as part of their regular contacts with the child and family.

APPENDIX F - AUDIT TRAIL

a. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.
2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.

2. Method of payments (check one):

Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

Other (Describe in detail):

b. BILLING AND PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services are made only: See page 59 "SED Billing Process"
 - a. When the individual was eligible for Medicaid waiver payment on the date of service;
 - b. When the service was included in the approved plan of care;
 - c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

Yes

No. These services are not included in this waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

All claims are processed through an approved MMIS.

MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

c. PAYMENT ARRANGEMENTS

1. Check all that apply:

The Medicaid agency will make payments directly to providers of waiver services.

The Medicaid agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.

The Medicaid agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims.

Providers may *voluntarily* reassign their right to direct payments to the following governmental agencies (specify):

Providers who choose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method: The provider must be eligible to enroll with Medicaid; all claims will be processed through Michigan's approved MMIS.

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency.

SED BILLING PROCESS

A SED database will be used to identify SED waiver eligibility dates. This data file will be e-mailed to Michigan Medicaid Information System (MMIS) staff weekly, and will be used to set the SED eligibility code and eligibility dates on MMIS. MMIS also contains Medicaid eligibility data for all Medicaid beneficiaries, including SED recipients. When claims are submitted to the MMIS for payment, the system checks for both Medicaid and SED eligibility data to assure the beneficiary was eligible for waiver and other Medicaid state plan services on the date of service.

Billing and reimbursement for SED services will be handled in conformance with policies and procedures as stipulated in the Michigan Medicaid Provider Manual. This manual provides direction to CMHSPs and other approved providers regarding requirements for billing services for waiver recipients. Providers can find additional information on billing, reimbursement, and third-party liability in the Medicaid Provider Manuals, available on-line at www.mdch.state.mi.us/dch-medicaid/mamuala/MedicaidProviderManual.pdf.

The SED site review will include a review of claims submitted to Medicaid by other providers for the “most recent 6-month period.” For each SED recipient whose record will be reviewed, team members develop a chart to compare 3 elements: services listed on the budget, services billed to Medicaid, and services identified in the POS. This review process will be used to assure that services billed and paid were included in the approved plan of care. (This review process is also used to assure the consumer receives services identified in the POS.)

APPENDIX G – FINANCIAL DOCUMENTATION

**APPENDIX G –1
COMPOSITE OVERVIEW
COST NETURALITY FORMULA**

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g. hospital and nursing facility), complete a Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE: Inpatient State Institutional Care

YEAR	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
1 Fiscal Year 2006	\$48,823	\$5,041	\$77,384	\$496
2 Fiscal Year 2007	\$53,625	\$5,041	\$77,384	\$496
3 Fiscal Year 2008	\$53,625	\$5,041	\$77,384	\$496
4	_____	_____	_____	_____
5	_____	_____	_____	_____

FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED
YEAR UNDUPLICATED INDIVIDUALS

1 43

2 43

3 43

4 _____

5 _____

EXPLANATION OF FACTOR C:

Check one:

_____ The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

X The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

See attachment on Calculation of Factor C

_____ The State will inform HCFA in writing of any limit which is less than factor C for that waiver year.

Calculation of Factor C

Number of unduplicated individuals served under the waiver.

Data source:

The number of recipients in the waiver is initially low and expected to grow over time. It is anticipated that 43 youth will be served each year of the three years under this initial SED Waiver application. The low number of individuals expected to participate in the waiver is attributed to several factors. First, the restrictive definition being used to make children eligible for the waiver will limit the number of individuals being served. Second, the collaboration it will take across systems to identify and then serve the children requiring this level of care is very complex. It will include screening many children as well as assessing children to make sure they meet the criteria identified in this waiver application. In addition, the design of the program and operational issues such as developing contracts, interagency agreements, creating services, training providers, building collaborative relationships and the development of the quality assurance program outlined will limit the number of participants. As community-based mental health and developmental disabilities services providers, such as CMHSPs, become familiar with the waiver and waiver communities demonstrate success, additional counties will participate.

APPENDIX G-2
METHODOLOGY FOR DERIVATION OF FORMULA VALUES

FACTOR D

LOC: Inpatient State Institutional Care

The July 25, 1994 final regulation defines Factor D as:

“The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program.”

The demonstration of Factor D estimates is on the tables on pages 67 through 69. Following these tables, on pages 70 through 72, is an explanation of the data sources and the description for the derivation of the estimates for Factor D.

Appendix G-2
Factor D
LOC: Inpatient State Institutional Care

Demonstration of Factor D Estimates
Waiver Year 1 XX 2 ___ 3 ___

<u>Column A</u>	<u>Column B</u>	<u>Column C</u>	<u>Column D</u>	<u>Column E</u>
Waiver Service / Unit of Service	Unduplicated # Recipients (users) Per Service	Average # Annual Units of Service Per User	Average Cost per Unit	Total Costs
Respite / 15 min.	43	1733	\$3.71	\$276,465.49
Therapeutic Camp, overnight / session	25	1	\$500	\$12,500.00
	18	17	\$66	\$20,196.00
Child Foster Care, Therapeutic / per diem	5	229	\$84	\$96,180.00
Wraparound / 15 min.	43	520	\$50	\$1,118,000.00
Community Living Services / 15 min.	43	3467	\$3.77	\$562,035.37
Community Transition / service	20	1	\$700	\$14,000.00
			Total per year	\$2,099,376.86
Factor D = Total per year divided by unduplicated # recipients per year				\$48,822.72

Estimated Number of Unduplicated Recipients: 43

Factor D (Divide total by number of recipients) = \$48,823.00

Average Length of Stay (ALOS): Ten Months¹

¹ The narrative on pages 64 - 70 of the original application has been consolidated and now follows the Factor D tables. The description for the derivation of the estimates for Factor D is now found on pages 70 through 72.

Demonstration of Factor D Estimates

Waiver Year 1__ 2 XX 3__

<u>Column A</u>	<u>Column B</u>	<u>Column C</u>	<u>Column D</u>	<u>Column E</u>
Waiver Service / Unit of Service	Unduplicated # Recipients (users) Per Service	Average # Annual Units of Service Per User	Average Cost per Unit	Total Costs
Respite / 15 min.	43	1907	\$3.71	\$304,223.71
Therapeutic Camp, overnight / session	25	1	\$500	\$12,500.00
	18	18	\$66	\$21,384.00
Child Foster Care, Therapeutic / per diem	5	252	\$84	\$105,840.00
Wraparound / 15 min.	43	572	\$50	\$1,229,800.00
Community Living Services / 15 min.	43	3813	\$3.77	\$618,125.43
Community Transition / service	20	1	\$700	\$14,000.00
			Total per year	\$2,305,873.14
Factor D = Total per year divided by unduplicated # recipients per year				\$53,624.96

Estimated Number of Unduplicated Recipients: 43

Factor D (Divide total by number of recipients) = \$53,625.00

Average Length of Stay: Eleven Months

Demonstration of Factor D Estimates

Waiver Year 1 2 3 **XX**

<u>Column A</u>	<u>Column B</u>	<u>Column C</u>	<u>Column D</u>	<u>Column E</u>
Waiver Service / Unit of Service	Unduplicated # Recipients (users) Per Service	Average # Annual Units of Service Per User	Average Cost per Unit	Total Costs
Respite / 15 min.	43	1907	\$3.71	\$304,223.71
Therapeutic Camp, overnight / session	25	1	\$500	\$12,500.00
	18	18	\$66	\$21,384.00
Child Foster Care, Therapeutic / per diem	5	252	\$84	\$105,840.00
Wraparound / 15 min.	43	572	\$50	\$1,229,800.00
Community Living Services / 15 min.	43	3813	\$3.77	\$618,125.43
Community Transition / service	20	1	\$700	\$14,000.00
			Total per year	\$2,305,873.14
Factor D = Total per year divided by unduplicated # recipients per year				\$53,624.96

Estimated Number of Unduplicated Recipients: 43

Factor D (Divide total by number of recipients) = \$53,625.00

Average Length of Stay: Eleven Months

Explanation of the data sources and methodology for the derivation of the estimates for Factor D.

Data Sources

Data from the following sources was used to estimate service utilization and the length of time children received the various types of services to be provided under this waiver.

- Data from a federally funded (SAMHSA-CMHS) pilot project in Wayne County (Southwest Detroit). The data is from FY 2002 and includes the type and amount of a particular service and the cost of the service per enrolled child. (N=169)
- Data from a Livingston County CMHSP pilot program providing case rate wraparound services to 19 Medicaid eligible individuals. The data is from FY 2002 and includes the type and amount of a particular service and the cost of the service per enrolled child. (N=19) Additional data from several partial fiscal years was used to estimate the average amount of time a child remained in wraparound services provided by the Livingston County CMHSP.
- Limited data from wraparound services provided to 466 children served by 20 Community Mental Health Service Programs (CMHSPs).
- Data from Michigan's Home and Community-based Children's Waiver (CWP) for selected services (e.g., Community Living Services).
- Encounter data reported by the CMHSPs.

Analysis and Calculations

1. The services provided in the pilot projects / programs were reviewed for relevance / conformance with the services expected to be provided under this waiver. The Healthcare Common Procedure Coding System (HCPCS) was then reviewed to identify applicable national codes, service descriptions and units of service.
2. For the children enrolled in the Livingston County and Southwest Detroit pilots, the number of Medicaid eligible children receiving each waiver service was identified, as was the unit of measure for each service and the total number of service units provided to each child. From that, the percentage of children receiving each waiver service, and the average number of units of service for users of each service, were computed. The results were used to determine the expected ratio of waiver service utilization.
3. The number of unduplicated recipients (users) for each waiver service was based on the total projected unduplicated number of waiver recipients, multiplied by the ratio of recipients in the pilot programs who received the service. This process was used for all services except therapeutic child foster care, family home care training, and overnight therapeutic camps.

4. Therapeutic child foster care is a new evidence-based mental health service in Michigan. Based on information from national experts and the clinical expertise of MDCH staff, the projected use of this service will be 10% of SED Waiver recipients, with the estimated amount of time in therapeutic child foster care being 9 months (275 days).
5. Overnight therapeutic camp is a new service for this target population. The estimate of projected usage for this service is based on the clinical expertise of MDCH staff and Michigan Department of Human Services data.
6. For family home care training, the estimates for the percentage of users and average amount of service used by each recipient, as well as the unit cost, are derived from the experience of the Children's Waiver Program.
7. Average unit cost was determined in a variety of ways: a) by using average cost in the Livingston County and Southwest Detroit pilot sites (wraparound services); b) web searches (overnight therapeutic camp); c) consultation with national experts (therapeutic child foster care); and d) Medicaid fee screens already in use in Michigan (respite, family home care training, and community living services).
8. The total cost of each service is the product of the following elements: the projected unduplicated number of users of each service (column B), the average number of annual units of service per user (column C), the average cost per unit of service (column D), service units per recipient using each service by the average length of stay for SED waiver recipients by the average unit cost established for each service.
9. The total cost per year for all waiver services was divided by the total number of unduplicated recipients ($N = 43$ for each year) to obtain Factor D.
10. Estimates for length of time in service are based on data from the pilot sites and from the Department's Medicaid Management Information System (MMIS), as follows: a) the average for Livingston CMH was based on all 34 closed cases for recipients open longer than three months from October 16, 2000 to February 28, 2003; b) the average for Southwest Detroit was based on FY 2002 data and included 169 unduplicated recipients receiving services longer than three months; and c) the average for wraparound services included data from 20 CMHSPs ($N=172$), for cases open longer than three months. Using an unduplicated count of recipients ($N=375$) from the three data sources and rounding to the highest whole number of months, the average length of time an individual received services was 12 months. (The cases closed with lengths of service less than three months were excluded because they were referred so late that wraparound could not be fully implemented before placement occurred and the case was closed.)
11. As the average length of time in service was 12 months, the above referenced data was also used to construct a 'base year' (i.e., to calculate the average number of annual units of service, per user, per service). For each Waiver service, the average number of annual units of service per user (column C) is the product of the service usage for the base year and the

average length of stay (ALOS) for each Waiver year. The following table indicates, by waiver service, the estimated average amount of service used for the 'base year'.

Respite Care Services, up to 15 minutes	2080 15 minute units
Therapeutic Camping, Overnight, per session	1 session
Home Care Training, Family, per session	20 sessions
Child Foster Care, Therapeutic, per diem	275 days
Community-based Wraparound, per 15 minutes	624 15 minute units
Comprehensive Community Support Services (Community Living Services), per 15 minutes	4160 15 minute units
Community Transition, per service	1 service

APPENDIX G-3

METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

- A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual (e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.

- B. The following service(s) are furnished in the home of a paid caregiver. (Specify): **Child Therapeutic Foster Care.** The approved costs for children's foster care, according to the Department of Human Services, Michigan's child welfare organization, are as follows:

Age Group	Room & Board	Personal Incidentals & Allowance	Clothing	Difficulty of Care Supplement	Daily Total
0-12	\$10.68	\$2.34	\$1.08	\$80.00	\$94.10
13-18	\$13.14	\$3.02	\$1.26	\$80.00	\$97.42

These costs are not included in the Children's Therapeutic Treatment Foster Care rates.

Once the Room & Board is subtracted from the total, the figures are \$83.42 for ages 0-12, and \$84.28 for ages 13-18. Taking the average of the two amounts and rounding up, the amount allowed for Child Therapeutic Foster Care is \$84/day.

See above explanation of the method used by the State to exclude Medicaid payment for room and board.

APPENDIX G-4

METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER

Check one:

X The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

_____ The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.

APPENDIX G-5

FACTOR D'

LOC: Inpatient State Institutional Care

NOTICE: On July 25, 1994, HCFA published regulations which changed the definition of factor D'. The new definition is:

"The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

The costs of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.

The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.

Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

APPENDIX G-5

FACTOR D' (cont.)

LOC: Inpatient State Institutional Care

Factor D' is computed as follows (check one):

Based on HCFA Form 2082 (relevant pages attached).

Based on HCFA Form 372 for _____ years of waiver # _____, which serves a similar target population.

Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

Other (specify): The narrative description for the derivation of the estimates of Factor D' is on the following pages (77-79).

Computation of D'

The annual average per capita Medicaid cost for all other (i.e., non-waiver services) was estimated, and a 'base year' was constructed. (See below for data sources and methodology.) Per instruction from CMS staff, D' is the same for year 1 through 3 of the SED waiver program, i.e., it has not been adjusted for average length of stay (ALOS) in the waiver.

Data Sources

The utilization and expenditures for other services provided to individuals in the waiver program was obtained from three sources:

- Data from a federally funded project (SAMHSA-CMHS) pilot project in Wayne County (Southwest Detroit). The data is from FY 2002 and includes the type and amount of a particular service and the cost of the service per enrolled child. (N= 169)
- Data from a Livingston County CMHSP pilot program providing case rate wraparound services to 19 Medicaid eligible individuals. The data is from FY 2002 and includes the type and amount of a particular service and the cost of the service per enrolled child. (N=19) Additional data from several partial fiscal years was used to estimate the average amount of time a child remained in wraparound services provided by the Livingston County CMHSP.
- Data from the Department's MMIS system for recipients in the above two pilot programs, for FY 2002.

Analysis and Calculations

- Recipient data from the pilot project was matched with MMIS data to obtain the number of pilot recipients who used other Medicaid services.
- Other categories of services utilized by pilot recipients were identified as follows:

Physician, M.D. And Physical Therapists	Dental Clinic
Physician, D.O.	Medical Clinic
Dentist	Hearing & Speech Center
Podiatrist/Chiropracist	Optical Company
Independent Clinical Laboratory	Medical Supplier
Health Maintenance Organization	Optometrist
Ambulance	Optical House
Community Mental Health Board - Outpatient	Home based
Family Planning Clinic	Psychiatric Evaluation
Hospital – Inpatient	Med Review
Hospital Outpatient	Therapy/Counseling
Pharmacy	Crisis residential
Psychological Testing	Behavioral Assessment

- For each category of service, the number of recipients receiving that category of service was identified from the MMIS and from the pilot data. In reviewing Medicaid State Plan mental health services, it was determined that the Livingston County CMHSP pilot data better represented usage expectations statewide because of the difficulty accessing mental health services and the lack of appropriate mental health services in Wayne County. Thus, for mental health services, the percentage of recipients in the Livingston County pilot program was used to estimate the amount of this service that would be used by SED Waiver recipients.
- Total expenditures for each category of service were identified from the data sources.
- For each physical health category of service, the average per capita cost was obtained by dividing the expenditures for that category of service by the number of pilot recipients receiving that category of service. For each mental health category of service, the average per capita cost was obtained by multiplying the cost per unit for the pilot recipients by the number of pilot units.
- The percentage of pilot recipients receiving each category of service was calculated by dividing the number of pilot recipients who receive each service by the total number of pilot recipients. For mental health services, just Livingston pilot data was used, as previously referenced.
- The projected number of waiver recipients receiving other services was calculated by multiplying the total number of unduplicated recipients in Year 1 (43) by the percentage of pilot recipients receiving each category of service.
- The projected expenditures for each category of service were calculated by multiplying the average per capita expenditure by the projected number of waiver recipients to receive the service.
- The projected expenditures for each category of service were totaled and then divided by the total number of unduplicated recipients in Year 1 (43) to obtain an overall per capita expenditure number.

D' Factor
Annual Average Per Capita Medicaid Cost for All Other Services Provided to Individuals in the Waiver Program

Other Medicaid Services	Number of Recipients Receiving Other Services		Expenditures for Other Services		Average Per Capita C=B/A	Recipients Receiving Other Services As A Percent of All Pilot Recipients D=A/188		Projected Number of Waiver Clients Receiving Other Services E=D*43		Projected Expenditures for Other Services F=(C*E)
	A	Other Services Provided in Year 1	B	Other Services Provided in Year 1		D=A/188	E=D*43			
Physician, M.D. and Physical Therapist	67	\$17,270	36%	15	\$258	3,950				
Physician, D.O.	28	\$3,493	15%	6	\$125	799				
Dentist	81	\$17,830	43%	18	\$220	4,078				
Podiatrist/Chiropracist	3	\$155	2%	1	\$52	35				
Independent Clinical Laboratory	22	\$1,408	12%	5	\$64	322				
Health Maintenance Organization	107	\$145,529	57%	25	\$1,360	33,286				
Ambulance	7	\$1,195	4%	2	\$171	273				
Community Mental Health Board - Outpatient	1	\$11,490	1%	0	\$11,490	2,628				
Family Planning Clinic	1	\$86	1%	0	\$86	20				
Hospital - Inpatient	6	\$33,981	3%	1	\$5,664	7,772				
Hospital - Outpatient	42	\$9,989	22%	9	\$238	2,285				
Pharmacy	96	\$79,920	51%	22	\$833	18,280				
Dental Clinic	21	\$2,388	11%	5	\$114	546				
Medical Clinic	58	\$79,880	31%	13	\$1,377	18,270				
Hearing & Speech Center	1	\$113	1%	0	\$113	26				
Optical Company	2	\$46	1%	0	\$23	11				
Medical Supplier	3	\$1,741	2%	1	\$580	398				
Optometrist	23	\$1,088	12%	5	\$47	249				
Optical House	14	\$324	7%	3	\$23	74				
Home Based	118	\$298,068	63%	27	\$2,526	68,175				
Psychiatric Evaluation	49	\$12,250	26%	11	\$250	2,802				
Med Review	128	\$31,872	68%	29	\$249	7,290				
Therapy/Counseling	60	\$43,800	32%	14	\$730	10,018				
Crisis Residential	9	\$29,880	5%	2	\$3,320	6,834				
Inpatient	30	\$119,940	16%	7	\$3,998	27,433				
Psychological Testing	9	\$2,250	5%	2	\$256	515				
Behavioral Assessment	9	\$1,800	5%	2	\$200	412				
Total Expenditures						216,781				
total Per Capita Expenditures						5,041				

Source of Data p Pilot data was matched to MMIS for all paid claims and recipient who had a date of service during 10/01 through 9/02. Data includes Medicaid eligible children under age 18 enrolled in the pilot who received other services. As individual could have received more than one service. There were 163 individual in the pilot who received other services.

APPENDIX G-6

FACTOR G

LOC: Inpatient State Institutional Care

The July 25, 1994 final regulation defines Factor G as:

"The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor G' the following:

The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.

The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

Computation of Factor G

Factor G is the estimated annual average per capita Medicaid cost for inpatient state institutional care that would be incurred for individuals served in each of the first 3 years of the waiver, were the waiver not granted. This factor is static for all years of the Waiver.

Data Source

The number of recipients served in the absence of the waiver and expenditures for services were obtained from MMIS data from FY 2002. This data identified 202 individual recipients under the age of 18 who had at least one date of service in a state institutional psychiatric hospital. The MMIS data from FY 2002 for children served in inpatient state institutional care indicates the total amount of funding paid was \$15,631,572.

Analysis and Calculations

- The total number of beneficiaries identified as using at least one inpatient state institutional day of care for FY 2002 is 202. Paid inpatient state institutional care claims for the 202 were calculated to be \$15,631,572.
- The average per capita Medicaid cost for inpatient state institutional care was determined by dividing the total expenditures (\$15,631,572) by the number of unduplicated recipients (202).
- The average per capita yearly cost for state institutional care is \$77,384.

Annual Average Per Capita Medicaid Cost for Inpatient State Institutional Care

Service	Base Year number of unduplicated recipients served in an institution	Base Year Expenditures	Average Per Capita Cost
Inpatient State Institutional Care	202	\$15,631,572	\$77,384

APPENDIX G-7

Factor G'

LOC: Inpatient State Institutional Care

The July 25, 1994 final regulation defines Factor G' as:

"The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor G' the following:

The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.

The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

Factor G' is computed as follows (check one):

Based on HCFA Form 2082 (relevant pages attached).

Based on HCFA Form 372 for years _____ of waiver # _____, which serves a similar target population.

Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

Other (specify): See below (page 83-84).

Computation of Factor G'

The estimated annual average per capita Medicaid cost for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted. Factor G' is static for all years of this SED waiver application.

Data Sources:

The number of recipients served in the absence of the waiver and the expenditures for other Medicaid services for these recipients were obtained from the state MMIS data for FY 2002. This data identified individual recipients under the age of 18 who had at least one day of service in a psychiatric hospital. For these individuals, utilization and expenditures for categories of service other than State institutional psychiatric hospitalization were identified from the MMIS system.

Analysis and Calculations:

- The Medicaid categories of service other than psychiatric hospitalization for recipients who were identified as being in an institution are listed below.

Physician, M.D. And Physical Therapists	Pharmacy
Physician, D.O.	Dental Clinic
Dentist	Medical Clinic
Independent Clinical Laboratory	Hearing & Speech Center
Health Maintenance Organization	Medical Supplier
Ambulance	Optometrist
Hospital Outpatient	Optical House

- For each category of service, the number of beneficiaries who utilized that service was identified from the MMIS data. The number of beneficiaries for each category of service is different because not all recipients received all other services while they were in a psychiatric hospital.
- Total expenditures for each category of service for recipients receiving other services were identified from the MMIS data.
- Taking the total expenditures for all of the other service categories and dividing this by the total number of individuals who received these services identified the total per capita expenditure. The following chart shows these expenditures.

Billing Provider Type	Medicaid Category of Service	Number of	Expenditures for	Average
		Recipients Served A	Other Services for Recipients in an Institution B	Per Capita C=(B/A)
10	Physician, M.D. And Physical Therapists	142	\$ 10,627	\$ 75
11	Physician, D.O.	31	\$ 2,889	\$ 93
12	Dentist	10	\$ 1,872	\$ 187
16	Independent Clinical Laboratory	1	\$ 10	\$ 10
17	Health Maintenance Organization	96	\$ 21,787	\$ 227
18	Ambulance	28	\$ 6,943	\$ 248
40	Hospital Outpatient	120	\$ 19,600	\$ 163
50	Pharmacy	26	\$ 2,429	\$ 93
74	Dental Clinic	52	\$ 626	\$ 12
77	Medical Clinic	18	\$ 645	\$ 36
80	Hearing & Speech Center	3	\$ 104	\$ 35
87	Medical Supplier	5	\$ 87	\$ 17
94	Optometrist	7	\$ 246	\$ 35
95	Optical House	4	\$ 115	\$ 29
TOTAL				
	Total Expenditures		\$ 67,980	
	Divided By Number of Recipients		<u>137</u>	
	Total Per Capita Expenditures		\$ 496	

Source of data - MMIS all paid claims for recipients with date of service during 10/01 - 9/02.
 Medicaid eligible children under 18 years of age who were hospitalized in a state institution.
 An individual could have received more than one category of service.

APPENDIX G-8
DEMONSTRATION OF COST NEUTRALITY
LOC: Inpatient state institutional care

YEAR 1

FACTOR D:	\$48,823		FACTOR G:	\$77,384
FACTOR D':	\$5,041		FACTOR G':	\$496
TOTAL:	\$53,864	≤	TOTAL	\$77,880

YEAR 2

FACTOR D:	\$53,625		FACTOR G:	\$77,384
FACTOR D':	\$5,041		FACTOR G':	\$496
TOTAL:	\$58,666	≤	TOTAL	\$77,880

YEAR 3

FACTOR D:	\$53,625		FACTOR G:	\$77,384
FACTOR D':	\$5,041		FACTOR G':	\$496
TOTAL:	\$58,666	≤	TOTAL	\$77,880

Factor D = Waiver services estimated

Factor D' = Other state plan Medicaid services (clinic, physician, lab work)

Factor G = State Inpatient Institutional costs

Factor G' = Other state plan Medicaid services during state inpatient institutional stay

APPENDIX H: QUALITY MANAGEMENT STRATEGY

The Quality Management Strategy that will be in effect during the period of the waiver is included I as Attachment #1 to this Appendix H.

The Quality Management Strategy must describe how the state will determine that each waiver assurance is met. The description must include:

- Activities or processes related to discovery, i.e., monitoring and recording the findings*
- Roles and responsibilities of those involved in measuring performance and making improvements. Include administrative entities identified in Appendix A, and individuals, advocates, providers, etc.
- The sources of data used to measure performance
- The frequency with which performance is measured

*Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery have been provided in the application in Appendices B, C, D, G, and I. These monitoring activities provide a foundation for QM by generating information that can be aggregated and analyzed to measure the overall performance of the system. The description of the QM strategy does not have to repeat those descriptions provided in other parts of the waiver application. Note: Due to submission of the existing waiver application, the above referenced Appendices are not applicable.

The Quality Management Strategy must describe the processes employed to review findings from its discovery activities, to establish priorities and to develop strategies for remediation and improvement.

The Quality Management Strategy must describe how the state compiles quality management information and communicates this information (in report or other format) to participants, families, waiver providers, other interested parties, and the public, including the frequency of dissemination.

The Quality Management Strategy must include periodic evaluation and revision to the Quality Management Strategy. Include a description of the process and frequency for evaluating and updating the Quality Management Strategy.

If the State's Quality Management Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Management Strategy, including the specific tasks that the State plans to undertake during the period that the waiver is in effect, the major milestones associated with these tasks and the entity (or entities) responsible for the completion of these tasks.

When the Quality Management Strategy spans more than one waiver and/or other types of long-term services under the Medicaid State Plan, specify the control numbers for the other waiver programs and identify the other long-term services that are addressed in the Quality Management Strategy.

Attachment #1 to Appendix H

OVERVIEW SUMMARY

Michigan's Quality Management Program (QMP) incorporates all of the programs operated in the public mental health system, including the HCBS waivers (B/C Control # MI-14.R02, Habilitation Support Waiver Control # 0167.90.R2, Children's Waiver Control #4119.90.R3, and, upon approval, the SED waiver). Regardless of fund source, approved community based mental health and developmental disability services providers, such as the CMHSPs adhere to the same standards of care for each individual served and the same data is collected for all consumers regardless of fund source. Each approved mental health and developmental disabilities service provider meets the standards for certification as specified in the Mental Health code and Medicaid program standards. The state agency responsible for the components of the quality management system identified below resides in the Michigan Department of Community Health's (MDCH) Division of Quality Management and Planning.

In addition to the quality management strategies listed below that are implemented for all consumers, the SED waiver staff, along with staff from the Children's Waiver Program (CWP) will conduct additional on-site reviews, using a SED Waiver Quality Management Protocol, to ensure that federal requirements and assurances of quality are met. The review staff includes a physician, nurse, limited licensed psychologist, and masters level social worker. These reviews will be on going, with every SED enrolled service provider reviewed at least bi-annually. A report of the findings is provided to the Department, along with a copy to the MDCH Manager of the QMP, and the MDCH Contract Manager. A plan of correction must be submitted to the Department in 30 days if the review staff identifies areas of improvement or noncompliance. Information shared with the MDCH contract managers is used by MDCH to take contract action as needed for system improvements. More specific information that details the focus areas is detailed in section V.E

I. BACKGROUND: PROCESS FOR QUALITY STRATEGY REVIEW AND REVISION

Since the approval of Michigan's 1915(b)(c) waiver application in 1997, there has been a Quality Management Program (QMP) in place for all programs (waivers) operated in Michigan's public mental health system that is revised with each subsequent waiver renewal application. This same system will be used to monitor the SED waiver. Michigan's original and subsequent QMPs have been developed with the input of consumers and the Mental Health Quality Improvement Council that is comprised of consumers and advocates, and representatives from the Provider Alliance and the Michigan Association of Community Mental Health Services Boards (CMHSPs). Michigan's most recent QMP, of which CMS is in receipt, reflects the activities, concerns, input or recommendations from the Michigan Mental Health Commission, MDCH's Encounter Data Integrity Team, MDCH's Administrative Simplification Process Improvement Team, the 2005 External Quality Review, and the terms and conditions from CMS' previous waiver

approval.

Michigan uses a fee-for-service delivery system to provide services to its SED Waiver recipients. The approved community-based mental health and developmental disability services providers, such as the CMHSPs provide the delivery system for the SED Waiver services. The MDCH contracts with Prepaid Inpatient Hospital Plans (PIHPs) that are typically composed of more than one CMHSP; in several instances, a single CMHSP is a PIHP. Both the Division of Quality Management and Planning and the SED waiver staff, within the Bureau of Community Mental Health Services of MDCH, review the approved community-based mental health and developmental disability services providers in part, through site visits.

The existing infrastructure in Michigan includes 1915(b) waiver authority to allow Michigan to provide mental health services not otherwise covered under the State plan through a managed care delivery system. The combined 1915(b) with the 1915(c) Habilitation Supports Waiver (HSW) for individuals with developmental disabilities enables Michigan to use typical Medicaid managed care program features such as quality improvement performance plans and external quality reviews to effectively monitor waiver programs. These same quality improvement performance plans and external quality reviews will be used to monitor the CMHSPs in their provision of SED Waiver services. Because the SED Waiver is a fee-for-service program and is not covered under Michigan's managed care delivery system, the CMHSPs typically are the delivery point for accessing and utilizing SED Waiver services.

II. CERTIFICATION, ACCREDITATION, AND LICENSURE

Community Mental Health Services Program Certification: The approved Plan for Procurement and the subsequent Application for Participation (2002) required that each PIHP be a community mental health services program (CMHSP). CMHSPs and other approved community-based mental health and developmental disability services providers must meet certification requirements as specified in Section 232a of the Michigan Mental Health Code (Code), Public Act 258 of 1974, as amended and the Administrative Rules, applicable thereto. These entities must be able to provide, either directly or under contract, a comprehensive array of services as specified in Section 206 of the Code.

It is required that the CMHSP and each of its subcontracting providers of mental health, and any other approved community-based mental health and developmental disability services provider, meet these standards. If a CMHSP, approved community-based mental health and developmental disability services provider, or its subcontracting provider is accredited by a national organization, a limited review of the accredited agency is conducted by MDCH beyond assuring the existence of said accreditation.

MDCH has granted deemed status to four national accrediting bodies: Joint Commission on Accreditation of Health Care Organizations (JCAHO), CARF, The Council on Accreditation (COA), and The Council. Certification may be granted for up to three

years. CMHSPs must be certified prior to entering into a prepaid contract for services and supports for beneficiaries.

III. APPLICATION FOR PARTICIPATION (AFP) & CONTRACTUAL REQUIREMENTS FOR PIHPS' QUALITY MANAGEMENT SYSTEMS

Three areas addressed by the Balanced Budget Act (BBA) and reviewed as part of the quality management system are: customer services, grievance and appeals mechanisms, and the quality assessment and performance improvement programs. These elements were required as part of the AFP (2002) and are now part of the MDCH/CMHSP contracts; and they are reviewed by MDCH staff and/or the external quality review process.

1. CUSTOMER SERVICES: The following minimum standards for customer services are covered by the MDCH on-site visit or the External Quality Review (EQR): (Note: these items are covered by the EQR.)

- a. Customer services operation is clearly defined.
- b. Customer service staff are knowledgeable about referral systems to assist individuals in accessing transportation services necessary for medically-necessary services (including specialty services identified by EPSDT)
- c. A range of methods are used for orienting different populations in the general community to the eligibility criteria and availability of services offered through the PIHP/CMHSP's network
- d. Customer services performance standards of effectiveness and efficiency are documented and periodic reports of performance are monitored by the PIHP/CMHSP.
- e. The focus of customer services is customer satisfaction and problem avoidance, as reflected in policy and practice
- f. Customer services is managed in a way that assures timely access to customer services and addresses the need for cultural sensitivity, and reasonable accommodation for persons with physical disabilities hearing and/or vision impairments, limited-English proficiency, and alternative forms of communications
- g. The relationship of customer services to required appeals and grievances processes, and recipient rights processes is clearly defined organizationally and managerially in a way that assures effective coordination of the functions, and avoids conflict of interest or purpose within these operations

PIHP/CMHSPs found out of compliance with these standards must submit plans of correction. MDCH staff and the EQR follow-up to assure that the plans of correction are implemented. Results of the MDCH on-site reviews and the EQRs are shared with MDCH Mental Health and Substance Abuse Management team, with the Quality Improvement Council (QIC) and will also be shared with the SED staff. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

2. Appeals and Grievances Mechanisms: The EQR reviews on-site the process, information to recipients and contractors, method for filing, provision of assistance to beneficiaries, process for handling grievances, record-keeping, and delegation. In addition, the logs of appeals and grievances and their resolutions at the local level are subject to on-site review by MDCH.. MDCH uses its Appeals database to track the trends of the requests for fair hearing and their resolution and to identify CMHSPs that have particularly high volumes of appeals. Results of the MDCH on-site reviews and the EQRs are shared with MDCH Mental Health and Substance Abuse Management team and with the QIC. The MDCH SED staff will also review those related to the consumers of the SED waiver Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

In addition, MDCH will utilize appeals data to assist in tracking changes in level of care (LOC) for all SED Waiver participants. MDCH SED Waiver staff will expand its LOC and Quarterly Review spreadsheet to track when a LOC change occurs, whether the participant's family appeals the change in LOC, and the Administrative Hearing results. MDCH will use appeals data to track LOC changes for SED Waiver participants and will provide a summary of these results to CMS in the quality assurance component of CMS annual reports.

3. Quality Assessment and Performance Improvement Programs: The MDCH contracts with PHIP/CMHSPs require that Quality Assessment and Performance Improvement Programs (QAPIP) be developed and implemented. The EQR monitors, on-site, the PHIP/CMHSPs' implementation of their local QAPIP plans that must include the 13 QAPIP standards. In addition, MDCH reviews on-site implementation of the following standards: sentinel Events and credentialing of providers. MDCH collects data for performance indicators and performance improvement projects as described below.

a. Performance Indicators

Please see section VI. of this Quality Strategy

b. Performance Improvement Projects

The MDCH staff collaborates to identify the performance improvement projects for the each waiver period. Justification for the projects was derived from analyses of quality management data, external quality review findings, and stakeholder concerns. For the upcoming waiver period, Michigan will require all PIHP/CMHSPs to conduct a minimum of two performance improvement projects;

1. All PIHP/CMHSPs conduct one mandatory two-year performance improvement project assigned by MDCH. In the case of PIHP/CMHSPs with affiliates, the project is affiliation-wide.
2. PIHP/CMHSPs that have continued difficulty in meeting a standard, or implementing a plan of correction, are assigned a project relevant to

the problem. All other PIHP/CMHSPs choose a performance improvement project in consultation with the QAPIP governing body.

PIHP/CMHSPs report semi-annually on their performance improvement projects. The EQR validates the PIHP/CMHSPs methodologies for conducting the projects. Results of the MDCH performance improvement project reports are shared with MDCH Mental Health and Substance Abuse Management team and with the Quality Improvement Council. Results related to the SED waiver, will be shared with SED staff. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

IV. EXTERNAL QUALITY REVIEW (EQR)

MDCH contracted with Health Services Assessment Group (HSAG) to conduct the EQR for two years, beginning June 2004. HSAG worked with MDCH and representatives from the PIHPs to adapt the Year One review protocols for Michigan. A similar approach will be employed for Year Two (June 2005-June 2006) and Year Three (June 2006-June 2007) of the EQR. The EQR consists of desk audits of PIHP documents and two-day on-site visits to each CMHP. The contents of the review for Years One, Two and Three are:

1. Validation of Performance improvement projects
2. Validation of performance indicators
3. Compliance with Michigan's Quality Standards per BBA

Results of the EQRs are shared with MDCH Mental Health and Substance Abuse Management team and with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

V. MDCH ON-SITE REVIEW OF CMHSPS: REVISED PROCESS FOR FY'06

The Division of Quality Management and Planning within MDCH monitors the waivers (including the SED waiver, upon approval) implementation at the 18 PIHPs (comprised of all CMHSPs), and sends a qualified site review team to each of the 18 PIHPs and 46 CMHSPs for each fiscal year. MDCH had proposed to CMS to conduct comprehensive biennial site visits to all PIHPs by the MDCH Division of Quality Management. During the alternate years, state staff visits PIHP/CMHSPs to follow-up on implementation of plans of correction resulting from the previous year's comprehensive review. As with the previous quality strategy, this site visit strategy incorporates for all beneficiaries served by all of Michigan's waivers the more rigorous standards for assuring the health and welfare of the 1915(c) waiver beneficiaries, including visits to beneficiaries' homes. The comprehensive reviews include the following components:

- A. Clinical Record Review: Reviews of clinical records to determine that person-centered/family-centered planning is being utilized, health and welfare concerns are being addressed if indicated, services identified in the plan of service are being delivered, and delivery of service meets program requirements that are published in the Medicaid Provider Manual. The MDCH review team draws random samples of clinical records to be drawn from encounter data in the

MDCH warehouse. Scope of reviews includes all Medicaid state plan and 1915(b)(3) services, and waiver programs (including the SED waiver, upon approval), all affiliates (if applicable), a sample of providers, and a sample of individuals considered "at risk" (persons in 24-hour supervised settings and those who have chosen to move from those settings recently)

- B. Administrative Review: The comprehensive administrative review will focus on policies, procedures, and initiatives that are not otherwise reviewed by the EQR and that need improvement as identified through the performance indicator system, encounter data, grievance and appeals tracking, sentinel event reports, and customer complaints. Areas of the administrative review focus on MDCH contract requirements including:
- PIHP/CMHSP Compliance with the Medicaid Provider Manual
 - Written agreements with providers, community agencies
 - The results of the PIHP/CMHSPs' annual monitoring of its provider network
 - Adherence to contractual practice guidelines
 - Sentinel event management
- C. Consumer/Stakeholder Meetings: During the biennial comprehensive review the team will meet with a group of consumers, advocates, providers, and other community stakeholders to determine the PIHP's progress to implement policy initiatives important to the group (e.g., person-centered/family-centered planning, rights, customer services); the group's perception of the involvement of beneficiaries and other stakeholders in the QAPIP and customer services; and the provider's responsiveness to the group's concerns and suggestions.
- D. Consumer Interviews: Review team members will conduct interviews with a random sample of those individuals whose clinical records were reviewed, using a standard protocol that contains questions about such topics as awareness of grievance and appeals mechanisms, person-centered planning and satisfaction with services. Interviews will be conducted where consumers reside in group homes or living independently with intense and continuous in-home staff or in the homes of families served by the CWP or SED waiver. Interviews of other consumers may be conducted in the provider's office or over the telephone.

A report of findings from the on-site reviews with scores will be disseminated to the PIHP/CMHSP with requirement that a plan of correction be submitted to MDCH in 30 days. On-site follow-up will be conducted the following year, or sooner if non-compliance with standards is an issue. Results of the MDCH on-site reviews are shared with MDCH Mental Health and Substance Abuse Management team, the Quality Improvement Council, and SED staff. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

- E. SED Waiver staff on-site reviews. The SED Waiver staff site review teams

monitor the following:

- Evaluation of level of care will include: assurance that enrolled participants are reevaluated at least annually (as documented by the completion of the Waiver Certification form and the Child and Adolescent Functional Assessment Scale [CAFAS]) by the case manager and other members of the child's person-centered planning (PCP) team, and that decisions are appropriate and well documented. When a level of care is not documented or supported the process described in the overview is implemented. Individual Plans are reviewed to ensure that: a PCP process is used to develop comprehensive plans that identify the participant's assessed needs (including health and safety), strengths, goals, and that the plan specifies the type, scope, amount, duration and frequency of service; plans are updated as needed, but at least annually; and that participants are given a choice of service providers, and waiver services over institutional care (documented on the SED Waiver Certification form).
 - This is done through a review of clinical records and consumer interviews; similar to the process described above.
 - Provider qualifications are reviewed to verify that the providers meet all required licensing, certification and training requirements.
 - Health and welfare is monitored by reviews of recipient rights complaints, sentinel events, behavioral management reviews for potentially seclusion and/or restrictive, reviews of the plans of service and consumer interviews to ensure that the child is receiving the services identified in the plan.
 - Financial Accountability involves a review of paid claims against services (type, frequency, duration) identified in the plan, prescriptions, and private insurance coverage..

VI. DATA SUBMISSION AND ANALYSES

- A. Performance Indicators: Medicaid performance indicators measure the performance of the PIHP/CMHSPs. The QIC revised the performance indicators in 2005. Domains that include access, adequacy, appropriateness, effectiveness, outcomes, prevention, and structure/plan management categorize the indicators.

Indicators are used to alert MDCH management of systemic or individual PIHP/CMHSP issues that need to be addressed immediately; to identify trends to be watched; to monitor contractual compliance; and to provide information that the public wants and needs. Most of the information used in these indicators is generated from the encounter and QI data located in MDCH's data warehouse. Any data that is submitted in the aggregate by PIHP/CMHSPs, and the methodologies for submission are validated by MDCH and the EQR. Analyses of the data results in comparisons among PIHP/CMHSPs and with statewide averages. Statistical outliers are reviewed to identify best practices and opportunities for improvement. Those entities found to have negative statistical outliers in more than two consecutive periods are the focus of investigation, and

may lead to PIHP/CMHSP contract action. Technical information from the performance indicators is shared with MHSP/CMHSPs; user-friendly information is shared with the public using various media, including the MDCH web site. Results of the performance indicators are shared with MDCH Mental Health and Substance Abuse Management team, the Quality Improvement Council and SED waiver staff. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

- B. Encounter and Quality Improvement Data: Participant level encounter data is reported electronically in HIPAA-compliant format each month for all services (including SED Waiver services) provided in the previous month and for which claims have been adjudicated. "Quality improvement" or demographic data are also reported monthly for each individual. Data are stored in MDCH's data warehouse where Medicaid Health Plan and Pharmacy encounter data, and fee-for-service data are also stored. Aggregate data from the encounter data system are shared with the MDCH Mental Health and Substance Abuse Management Team, The Encounter Data Integrity Team (EDIT), and the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements. The SED Waiver staff review data from the warehouse for selected participation and for individuals whose records will be reviewed as part of an on-site review. This review process is used to ensure that services billed to and paid by the SED Waiver were included in the approved POC. This review process is also used to assure the participant receives services identified in the POS.
- C. Medicaid Sub-element Cost Data: PHIPs are required by contract to submit Medicaid sub-element cost reports annually. The cost reports provide numbers of cases, units, and costs for each covered service provided by PHIP. The report also includes the total Medicaid managed care administrative expenditures and the total Medicaid expenditures for the PHIP. This data enables MDCH to crosscheck the completeness and accuracy of the encounter data. Cost data are shared with MDCH Mental Health and Substance Abuse Management team, the Encounter Data Integrity Team (EDIT), and with the QIC. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

The SED Waiver database is used to identify SED recipients and eligibility dates. This data file is used to update Michigan's MMIS weekly. When claims are submitted for payment, they are run against both the Medicaid and SED Waiver eligibility data to assure the beneficiary was eligible for Medicaid waiver payment on the date of service. This process, in conjunction with an annual MDCH review of the participants' budgets enables MDCH to manage the amount appropriated to the SED Waiver.

- D. Sentinel Events: Sentinel events are reported, reviewed, investigated and acted upon at the local level by each PIHP for the following persons: those receiving

Targeted Case Management, enrolled in the Habilitation Supports Waiver, live in 24-hour specialized residential settings, or live in their own homes receiving ongoing and continued personal care services. For the Children's Waiver and the SED waiver sentinel events will be reviewed, investigated and acted upon at the local level by each and CMHSP and reported to MDCH directly. This information is reported in the aggregate to the MDCH semi-annually. Sentinel events include but are not be limited to: death of the recipient, any accident or physical illness that requires hospitalization, suspected abuse and neglect of a recipient, incidents that involve arrest or conviction of the recipient, serious challenging behaviors (e.g., property damage, attempts at self-inflicted harm or harm to others, or unauthorized leaves of absence) and medication errors.

Michigan law and rules require the mandatory reporting of the issues above within 48 hours to the CMHSPs' Office of Recipient Rights (ORR) for all others. This information is reviewed for trends, and becomes a focus of the on-site visitation conducted by MDCH to CMHSPs. Aggregate data are shared with MDCH Mental Health and Substance Abuse Management team, the Quality Improvement Council and waiver staff. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements.

- E. Recipient Rights: Semi-annually, local CMHSP ORRs report summaries of all allegations received and investigated, whether there was an intervention, and the numbers of allegations substantiated. The summaries are reported by category of rights violations, including: freedom from abuse, freedom from neglect, right protection systems, admission/discharge/second opinion, civil rights, family rights, communication and visits, confidentiality, treatment environment, suitable services, and treatment planning. An annual report is produced by the state ORR and submitted to stakeholders and the Legislature. Data collection improvements will distinguish Medicaid beneficiaries from other individuals served. This information is aggregated to the PIHP level where affiliations of CMHSPs exist. Aggregate data are shared with MDCH Mental Health and Substance Abuse Management team, the QIC, and waiver staff. Information is used by MDCH to take contract action as needed or by the QIC to make recommendations for system improvements. MDCH is currently examining the possibility of cross matching waiver identifiers with the local ORRs data. If it is determined that a cross matching can be obtained, then the SED Waiver program will be able to separately report sentinel events and recipient rights allegations for SED Waiver participants.
- F. Service Agency Profiles: CMHSPs are required to submit to MDCH information about each of their Medicaid service providers at least every three years with interim updates as necessary (e.g., changes/additions of new providers: termination of contracts, change in accreditation status, change of address). This information is kept in a database and is used by the Mental Health and Substance Abuse Administration to verify the capacity of the service network.