MI Choice Waiver

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SECTION 1 – GENERAL INFORMATION

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

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

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

SECTION 2 – ELIGIBILITY

The MI Choice program is available to persons who are either elderly (age 65 or older) or adults with disabilities age 18 or older and meet the following eligibility criteria:

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

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

2.1 FINANCIAL ELIGIBILITY

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

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

2.2 FUNCTIONAL ELIGIBILITY

The MI Choice waiver agency must verify an applicant's functional eligibility for program enrollment using the LOCD application in CHAMPS. Waiver agencies must conduct an LOCD in person with an applicant and submit that information in the LOCD application in CHAMPS, or the agency may adopt an existing LOCD conducted by another provider. The information submitted is put through an algorithm within the application to determine whether the applicant meets LOCD criteria. Only the LOCD application in CHAMPS can determine functional eligibility for the nursing facility level of care. Additional information can be found in the Nursing Facility Level of Care Determination Chapter and is applicable to MI Choice applicants and participants.

2.2.A. Freedom of Choice [Changes Made 4/1/2026]

Prior to MI Choice enrollment, all applicants and their legal representatives must be given information regarding all Medicaid long-term services and supports options for which they qualify through the LOCD, including MI Choice, Nursing Facility, MI Health Link/MI Coordinated Health HCBS Waiver, **(revised per bulletin MMP 25-47)** and the Program of All-Inclusive Care for the Elderly (PACE). Qualified applicants may only enroll in one long-term services and supports program at any given time. Nursing facility, PACE, MI Choice, MI Health Link/MI Coordinated Health, and Home Help services cannot be chosen in combination with each other. Applicants must indicate their choice, subject to the provisions of the Need for MI Choice Services subsection of this chapter, and document via their signature and date that they have been informed of their options through the Freedom of Choice (FOC) form that is provided to an applicant at the conclusion of any LOCD process. Applicants must also be informed of other service options that do not require Nursing Facility Level of Care, including Home Health and Home Help State Plan services, as well as other local public and private service entities. The FOC form must be signed and dated by the supports coordinator and the applicant (or their legal representative) seeking services and is to be maintained in the applicant's case record and a copy provided to the applicant or participant upon request. Additional information can be found in the Nursing Facility Level of Care Determination Chapter.

The FOC form must be completed with each conducted LOCD and any time an LOCD is adopted. Waiver agencies must make a considerable effort to obtain all necessary signatures. If the waiver agency is unable to obtain signatures from the beneficiary, or their representative, the attempts to get signatures must be documented. While informing the beneficiary of available choices for the receipt of long-term services and supports is the main reason for the FOC form, this form also serves to verify that the waiver agency conducted an LOCD. Should there be any issues with the LOCD being uploaded and saved in CHAMPS, the FOC form will provide verification that the LOCD was conducted and whether the beneficiary met LOCD.

2.3 Need for MI Choice Services

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

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

2.4 Excluded from Eligibility [Change Made 4/1/2026]

The MI Choice population specifically excludes the following groups:

- Medicaid-eligible persons who reside in intermediate care facilities for individuals with intellectual disabilities (ICF/IID) or a state psychiatric hospital,

- Medicaid-eligible persons enrolled in a qualified health plan (e.g., health maintenance organization) or managed care organization,
- Persons enrolled in PACE,
- Persons enrolled in the Habilitation Supports Waiver program,
- Persons enrolled in the MI Health Link/MI Coordinated Health **(revised per bulletin MMP 25-47)** program,
- Persons enrolled in the Home Help Services program whose service and support needs are fully met by that program,
- Persons enrolled in the Healthy Michigan Plan,
- Nursing facility residents, and
- Medicaid-eligible persons admitted to a hospice or palliative care facility.

SECTION 3 – ENROLLMENT

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

3.1 GENERAL PROVISIONS OF PARTICIPATION

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

3.1.A. ENROLLMENT IN OTHER PROGRAMS AND PROGRAM ENROLLMENT TYPES [CHANGE MADE 4/1/2026]

A program participant cannot be simultaneously enrolled in both MI Choice and a Medicaid Health Plan, PACE, MI Health Link/MI Coordinated Health, **(revised per bulletin MMP 25-47)** or any other §1915(c) waiver program. Applicants must choose one program in which they wish to enroll. It is not necessary to either delay MI Choice enrollment or withhold MI Choice services pending the disenrollment process from any of the Medicaid Health Plans, but some programs require the individual to enroll on the first day of the month and disenroll only on the last day of the month. Enrollment and disenrollment policies for other programs must be followed to determine when to enroll someone in MI Choice.

Waiver agencies submit enrollment information directly to CHAMPS and CHAMPS will assign the appropriate MI Choice PET code once all information required is verified.

3.1.A.1. HOSPICE ENROLLMENT

A participant in the MI Choice program may receive Hospice services simultaneously when in a home and community-based setting. The individual must not be residing in a nursing facility or hospice residential facility while receiving MI Choice services. Individuals who are enrolled in both MI Choice and Hospice will have a PET code indicating this. For additional information regarding Hospice services, refer to the Hospice Chapter of this Manual. Participants who receive both MI Choice and Hospice or Palliative Care services must have a coordinated person-centered plan (PCP). MDHHS may employ a post-payment review to monitor services. If MDHHS finds that inappropriate (i.e., duplicative) services were authorized, MDHHS will seek recovery of Medicaid funds paid for duplicative services from the waiver agency.

3.1.A.2. Medicaid Qualified Health Plans (QHP)

An applicant enrolled in a Medicaid Qualified Health Plan (QHP) must choose between MI Choice services or the QHP. A Medicaid recipient cannot receive MI Choice services and enroll in the Medicaid QHP. When an applicant chooses MI Choice, the waiver agency will enter MI Choice enrollment information directly in CHAMPS.

3.1.A.3. Nursing Facility Admissions

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

3.1.A.4. Hospital Admissions

A hospital admission is not an enrollment in a Benefit Plan or PET. Generally, waiver agencies do not provide MI Choice services, other than supports coordination (SC) and possibly continuation of a personal emergency response system (PERS), to participants while hospitalized.

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

3.1.A.5. Enrollment in MI Health Link/MI Coordinated Health [Title Revised & Changes Made 4/1/2026]

Individuals enrolled in MI Health Link/MI Coordinated Health cannot also enroll in MI Choice. Individuals should be referred to a Medicare/Medicaid Assistance Program counselor for options counseling before deciding to opt-out or disenroll from MI Health Link or disenroll from MI Coordinated Health. Michigan ENROLLS handles all enrollments, disenrollments and opt-outs for MI Health Link. The Highly Integrated Dual Eligible Special Needs Plans (HIDE-SNPs) handle all enrollments, disenrollments, and opt-outs for MI Coordinated Health. All MI Health Link/MI Coordinated Health disenrollments are effective on the last day of a month. Normally, this is the last day of the month of the request. In MI Health Link, for requests made later in the month, the disenrollment may not take effect until the last day of the month following the month of the request. Eligible individuals may enroll in MI Choice after the effective date of the MI Health Link/MI Coordinated Health disenrollment.

MI Health Link/MI Coordinated Health has nine PET codes depending upon the living arrangement of the individual.

Waiver agencies will need to coordinate enrollments with the MI Health Link/MI Coordinated Health discharge to ensure the proper MI Choice PET sets on the day of MI Choice enrollment. MI Health Link/MI Coordinated Health discharges will be effective on the last day of the month. Therefore, MI Choice must not enroll until the first day of the following month. **(revisions made per bulletin MMP 25-47)**

3.1.B. Institutional Stays

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

A short-term hospital admission does not necessarily impact a participant's MI Choice enrollment status. The participant's supports coordinator must temporarily suspend the delivery of MI Choice waiver services during the hospital stay to avoid duplication of services from the hospital and MI Choice; however, the participant may remain enrolled in MI Choice. A participant who is hospitalized for more than 30 consecutive days must be disenrolled.

A participant admitted to a nursing facility for rehabilitation services or for any reason other than an approved short-term out-of-home respite stay must be disenrolled from MI Choice on the date prior to the nursing facility admission. The individual may be re-enrolled into MI Choice upon discharge from the nursing facility as long as the individual meets eligibility criteria as described in the Eligibility section of this chapter.

3.2 MI Choice Intake Guidelines

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

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

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

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

When an applicant appears to be functionally eligible based on the MIG but is not expected to meet the financial eligibility requirements, the MI Choice waiver agency must place the applicant on the waiting list if it is anticipated that the applicant will become financially eligible within 60 days.

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

3.3 Enrollment Capacity

MI Choice capacity is limited to a maximum number of participants served at any point in the fiscal year as specified in the approved waiver application. Waiver agencies are allocated a specific number of slots each fiscal year and are responsible for managing enrollment so as not to exceed the maximum number of participants served at any point in the fiscal year. MDHHS reserves the right to reallocate slots as necessary to best meet MI Choice program demands.

3.4 Waiting Lists

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

3.4.A. Priority Categories

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

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

3.4.A.1. State Plan Private Duty Nursing Age Expirations

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

3.4.A.2. Nursing Facility Transitions

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

3.4.A.3. Adult Protective Services (APS) and Diversions

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

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

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

3.4.A.4. Chronological Order by Service Request Date

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

3.4.B. Removing Applicants from Waiting List

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

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

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

3.5 Enrollment Slots

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

3.6 Enrollment in MI Choice

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

3.6.A. First Day of Enrollment [Changes Made 4/1/2026]

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

- The waiver agency assesses an applicant in a nursing facility or hospital, or the applicant has another Medicaid PET code assigned at the time of the assessment.
  - On a date following assessment, the applicant returns home, to the community, or terminates participation in the other Medicaid program. MI Choice enrollment may begin only after the individual returns home or terminates participation in the other program.
  - Waiver agencies coordinate with the MDHHS Field Office or the other program to ensure termination from the other program before enrolling the participant in MI Choice. As a reminder, individuals transferring from MI Health Link/MI Coordinated Health, PACE, or the Habilitation Supports Waiver may only do so on the first of the month. Waiver agencies submit enrollment information in CHAMPS.
  - The waiver agency establishes the applicant's enrollment date on a date following discharge from the nursing facility, hospital, or other program. MI Choice enrollments can occur on the day of discharge from the nursing facility or hospital. The enrollment date must not be the assessment date when the individual was assessed while in the nursing facility or hospital unless the assessment date was the day of discharge from the nursing facility or hospital.
- An applicant is hospitalized after the waiver agency conducts an assessment. The waiver agency must delay establishing the enrollment date until after the applicant is discharged from the hospital.
- The applicant currently participates in the Home Help Services program. The waiver agency verifies and documents that the Home Help Services program no longer meets the service and support needs of the applicant. Waiver agencies may only make this determination through an in-home assessment and evaluation of the applicant. Waiver agencies MAY NOT require the individual to request and have additional Home Help Services benefits denied before making this determination.
  - The waiver agency requests termination of the Home Help Services program before MI Choice enrollment and asks the applicant to notify the MDHHS Field Office of this decision to terminate the Home Help Services program enrollment.
  - Participants are entitled to receive State Plan services while in MI Choice; however, MI Choice will meet all personal care needs so that the individual does not require Home Help Services when enrolled in MI Choice. The supports

coordinators (SCs) should fully explain this choice to applicants requesting to switch from the Home Help Services program to MI Choice.

- An applicant is assessed at the end of a month. The waiver agency, with approval from the applicant, may establish the MI Choice enrollment date on the first day of the following month.
- The waiver agency assesses the applicant and determines the applicant meets LOCD criteria but has excess assets. The waiver agency shall delay enrollment into MI Choice until the MDHHS Field Office determines the applicant financially eligible.
- The applicant is enrolled in another managed long term services and supports (LTSS) program, including MI Health Link/MI Coordinated Health, PACE and Habilitation Supports Waiver, at the time of assessment. These are managed care programs where disenrollment is effective at the end of the month. The waiver agency will have to coordinate the MI Choice enrollment date to be the first day of the month after the effective date of the MI Health Link/MI Coordinated Health, PACE or Habilitation Supports Waiver disenrollment. **(revisions made per bulletin MMP 25-47)**
- The applicant does not have Medicaid at the time of assessment. Before the waiver agency can presume the applicant eligible for MI Choice, the applicant must submit a Medicaid application to the MDHHS Field Office. The waiver agency has several choices once the Medicaid application is in the approval process.
  - Do not enroll until Medicaid eligibility is confirmed. The waiver agency may wait to determine the MI Choice enrollment date. The waiver agency notifies the MDHHS Field Office that it has assessed the applicant and determined the applicant meets all eligibility criteria, except Medicaid eligibility. This means the applicant has been approved for the waiver. The waiver agency will not enroll the applicant in MI Choice until the MDHHS Field Office confirms Medicaid eligibility. The waiver agency should not enter enrollment information into CHAMPS until Medicaid eligibility is determined and the enrollment date is verified. MI Choice enrollment occurs when all eligibility criteria has been confirmed and the waiver agency starts providing MI Choice services. In this situation, the first date of MI Choice enrollment cannot be sooner than the date the MDHHS Field Office confirms Medicaid eligibility, regardless of any retroactive Medicaid eligibility dates. It may be necessary to complete an additional LOCD or interRAI Home Care (iHC) assessment depending on the length of time it takes the MDHHS Field Office to make this determination. The waiver agency cannot assign the applicant a status of Waiver/Pending or Waiver/Yes from the date of assessment to the date of Medicaid eligibility confirmation. The applicant may have an eligibility status of Waiver/Ineligible or Waiver Financially Ineligible while waiting for the Medicaid confirmation.
  - Presume eligible and MDHHS confirms Medicaid eligibility. The waiver agency may presume the MDHHS Field Office will approve the applicant's Medicaid application. The waiver agency notifies the MDHHS Field Office that it has assessed the applicant and determined the applicant meets all eligibility criteria, except Medicaid eligibility, and has determined the applicant "approved" for the waiver. The waiver agency may enter the MI Choice enrollment date in CHAMPS. The MI Choice PET will set once CHAMPS is able to verify Medicaid eligibility via data transfers from Bridges. The waiver agency implements the full

array of services identified in the applicants' person-centered service plan (PCSP) and proceeds as if the applicant met all eligibility criteria. In this situation, the waiver agency may assign a status of Waiver/Pending to the applicant. Once the MDHHS Field Office confirms Medicaid eligibility, the waiver agency may change the Waiver/Pending status to Waiver/Yes as of the date of the initial assessment or the first day of Medicaid eligibility, whichever is later. If the first day of Medicaid eligibility is later than the initial assessment date, the waiver agency reclassifies the days from the initial assessment date to the first date of Medicaid eligibility to Waiver/Ineligible in the status tables. The waiver agency will need to notify MDHHS Home and Community Based Services Staff to correct the initial MI Choice enrollment date in CHAMPS.

- Presume eligible, but MDHHS denies Medicaid eligibility. The waiver agency may presume the MDHHS Field Office will approve the applicant's Medicaid application. The waiver agency notifies the MDHHS Field Office that it has assessed the applicant and determined the applicant meets all eligibility criteria, except Medicaid eligibility, and has determined the applicant "approved" for the waiver. The waiver agency implements the full array of services identified in the applicant's PCSP and proceeds as if the applicant met all eligibility criteria. In this situation, the waiver agency may assign a status of Waiver/Pending to the applicant. The waiver agency may enter the MI Choice enrollment date in CHAMPS. The MI Choice PET will set once CHAMPS is able to verify Medicaid eligibility via data transfers from Bridges. Once the MDHHS Field Office denies Medicaid eligibility, the waiver agency must change the Waiver/Pending status to Waiver/Ineligible as of the date of the initial assessment. The waiver agency will need to notify MDHHS Home and Community Based Services Staff to delete the MI Choice enrollment date in CHAMPS.

3.7 MI Choice Enrollment Notification to the MDHHS Field Office

The waiver agency notifies the MDHHS Field Office of MI Choice participant enrollment and disenrollment dates, as well as subsequent changes made to MI Choice enrollment and disenrollment dates. Waiver agencies are required to do the following:

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

3.8 Participant Classification and Status Type

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

3.8.A. Participant Program Classifications

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

WA = Waiver

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

Waiver Eligible Status Classifications

Y (Yes)	The participant meets LOCD criteria, the MDHHS Field Office determined financial eligibility, the participant requires at least one MI Choice service in addition to supports coordination, and the participant agrees to enroll in MI Choice. The participant must not be residing in a nursing facility or hospital for this classification.
N (No)	The participant is not enrolled in or does not qualify for MI Choice.
P (Pending)	The participant meets NFLOC and requires at least one MI Choice service in addition to supports coordination, but the waiver agency is awaiting confirmation of financial eligibility from the MDHHS Field Office. Waiver agencies can use the "Pending" status only when the Medicaid application has been completed and submitted to the MDHHS Field Office, and the waiver agency has preliminarily determined (presumed) the participant is likely to meet financial eligibility requirements.
I (Ineligible)	The participant did not meet at least one of the eligibility criteria for MI Choice.

Transition/Diversion Case Status

No	The participant was not transitioned from the nursing facility.
Diverted	The participant met Imminent Risk Criteria as approved by MDHHS in the Community Transition Services Portal and has enrolled in the MI Choice program.
Transitioned	The waiver agency submitted and MDHHS approved the appropriate information in the Community Transition Services Portal, the participant transitioned from a nursing facility, and the participant has enrolled in the MI Choice program.

Self-Determination (SD)

Yes	Indicates the participant is enrolled in the MI Choice program and has chosen the self-determination option for delivery of services.
No	Indicates the participant has not chosen the self-determination option for the delivery of services.

Memorandum of Understanding (MOU)/Special Memorandum of Understanding (SMOU)

No	Indicates the participant does not qualify for a MOU or a SMOU.
SMOU	Indicates this person meets the significant support participant criteria for the purposes of capitation rates as specified in Attachment Q of the MI Choice Contract.

Case or Open Status Classifications

A	Indicates the participant is on open maintenance status.
0	Indicates the participant is on open active status.

Requirements:

- The waiver agency is responsible for confirming participant case classifications for program participants and to monitor the accuracy of participant data records.
- Waiver agencies must track MI Choice eligibility dates and statuses accurately in MI Choice Information System (MICIS), COMPASS, or a compatible database.
- Participants have one program classification, eligibility, transition, self-determination, and case status classification during a single duration of time, with the exception of individuals who are in the process of transitioning from the nursing facility, and are expected to enroll in MI Choice.
- Waiver agencies have written procedures to establish program status for MI Choice participants and to maintain and monitor the accuracy of participant data records.
- When a waiver agency uses "Pending" waiver eligible status classification, the waiver agency must provide the participant with the full array of MI Choice services as specified in the PCSP. When the MDHHS Field Office confirms the participant's eligibility for Medicaid, the waiver agency may then reclassify the participant with "Yes" waiver eligibility status. The waiver agency may choose to begin the "Yes" waiver eligibility status from either the MI Choice assessment date or the start date of MI Choice services when the MDHHS Field Office grants Medicaid eligibility retroactive to the assessment date. If Medicaid eligibility begins after the assessment date, the waiver agency must use the first date of Medicaid eligibility as the start date of "Yes" waiver eligibility status.
- When the waiver agency is unable to presume financial eligibility for the participant, the agency must use the "Ineligible" waiver eligibility status classification. The waiver agency cannot begin MI Choice services until it receives confirmation from the MDHHS Field Office of the participant's eligibility for Medicaid. When the MDHHS Field Office

confirms the participant's eligibility for Medicaid, the waiver agency may then reclassify the participant with "Yes" waiver eligibility status. The waiver agency may choose to begin the "Yes" waiver eligibility status from either the date of the MDHHS Field Office notification of Medicaid eligibility or the start date of MI Choice services.

- Waiver "Pending" status should not remain on closed cases. Once a case is closed and the MDHHS Field Office has made a Medicaid determination, the participant is either waiver eligible or not. The eligibility is no longer "Pending". Waiver agencies must have policies and procedures in place for periodically reviewing all participants with waiver "Pending" status and making adjustments to that status as indicated. Waiver "Pending" is only used for participants whose eligibility status has not yet been determined.

3.9 RE-ENROLLMENT

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

- The waiver agency must either adopt an existing LOCD or conduct the LOCD according to the requirements set forth in the Nursing Facility Level of Care Determination chapter of this Manual for each re-enrollment, regardless of the reason for the original discharge or program termination.
- The participant must meet all eligibility requirements for the MI Choice program.
- A reassessment may be required before the waiver agency can re-enroll the participant. A reassessment is required if:
  - The waiver agency completely closed the participant to all agency services, regardless of the length of time between closing and re-enrolling the participant.
  - The participant experienced a change in status. A change in status includes, but is not limited to, a medical event (such as a heart attack, stroke, broken bone, or organ transplant) that changed the participant's functional ability, a change in the availability of the participant's informal supports, a noticeable change in the participant's cognitive ability, or a change in the participant's financial situation.
  - The participant has been ineligible for or otherwise out of the MI Choice program for more than one month but remains an open participant with the waiver agency.
- Supports Coordinators (SCs) may perform assessments for a re-enrollment alone or using a team of a registered nurse (RN) and social worker (SW). However, MDHHS requires an RN/SW team in the following situations:
  - The waiver agency completely closed the participant to all agency services, regardless of the length of time between closing and re-enrolling the participant.
  - The participant experienced a change in status related to a decline in the participant's functional ability, informal support availability, or cognitive ability.
  - The participant has been ineligible for or otherwise out of the MI Choice program for at least 90 days.

- In emergency situations (i.e., when a re-enrollment is to occur within the next three days) when the waiver agency cannot schedule a team reassessment, one SC may start the reassessment process to ensure the participant meets MI Choice eligibility requirements and to develop a temporary PCSP. A SC of the other discipline shall complete the in-person reassessment within seven days of the time the reassessment process began.

3.10 Case Closure

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

- Death. The SCs shall close the waiver case upon the death of the participant. The last date of waiver enrollment cannot exceed the date of death.
- Moved, Transferred
- Moved, Not Transferred
- Not Eligible
- Nursing Facility Placement
- Refused Service
- ICF/IID Placement
- Transferred to Another Waiver Agency
- Transferred to Another Agency
- Moved to Case Management with other programs
- Hearing
- For Cause
- Administrative
- Other

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

SECTION 4 – SERVICES

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

- indicated by the current assessment;
- detailed in the person-centered service plan (PCSP); and
- authorized in accordance with the provisions of the approved waiver.

Services must not be authorized unless they are defined in the PCSP and must not precede the establishment of a PCSP. Waiver agencies cannot limit in aggregate the number of participants receiving a given service or the number of services available to any given participant. Participants have the right to receive services from any willing and qualified provider within the waiver agency's provider network. When the waiver agency does not have a willing and qualified provider within their network, the waiver agency must utilize an out-of-network provider at no cost to the participant until an in-network provider can be secured. (Refer to the Providers section of this chapter for information on qualified provider standards.)

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

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

Services paid for with MI Choice funds must not duplicate nor replace services available through the State Plan. Where applicable, the participant must use State Plan, Medicare, or other available payers first. MI Choice is the funding source of last resort. The participant's preference for a certain provider is not grounds for declining another payer in order to access waiver services.

Providers must have previous relevant experience or training for the tasks specified and authorized in the PCSP. The waiver agency must deem the chosen provider capable of performing the required tasks.

For services involving transportation paid for with MI Choice funds, the Secretary of State must appropriately license all drivers and vehicles, and all vehicles must be appropriately insured as required by law.

Healthcare Common Procedure Coding System (HCPCS) codes for each service can be found in the Directory Appendix of the Medicaid Provider Manual.

4.1 COVERED WAIVER SERVICES

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

4.1.A. ADULT DAY HEALTH

Definition	Adult Day Health services are furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the PCSP, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Meals provided as part of these services shall not constitute a "full nutritional regimen" (i.e., three meals per day). Physical, occupational and speech therapies may be furnished as component parts of this service. All Adult Day Health providers must comply with the federal Home and Community Based Settings Final Rule. Requirements are described in the Home and Community Based Services chapter of this Manual.
Requirements	Each program must keep all participant files confidential in controlled access files. Each program must use a standard release of information form that is time limited and specific as to the released information. Each program must maintain comprehensive and complete files that include, at a minimum: ▪ Details of the participant's referral to the adult day health program, ▪ Intake records, ▪ A copy of the MI Choice assessment (and reassessments), ▪ A copy of the MI Choice PCSP, ▪ Listing of participant contacts and attendance, ▪ Progress notes in response to observations (at least monthly), ▪ Notation of all medications taken on premises, including: ➢ The medication; ➢ The dosage; ➢ The date and time of administration; ➢ The initials of the staff person assisting with administration; and ➢ Comments ▪ Notation of basic and optional services provided to the participant, ▪ Notation of all releases of information about the participant, and ▪ A signed release of information form. Each program must provide directly, or arrange for, the provision of the following services. If the program arranges for provision of any service at a place other than program-operated facilities, a written agreement specifying supervision requirements and responsibilities must be in place. For MI Choice participants, the waiver agency must provide supports coordination. ▪ Transportation. ▪ Personal Care. ▪ Nutrition: One hot meal per eight-hour day which provides one-third of the recommended daily allowances and follows the meal pattern specified in the home-delivered meals service standard. Participants attending from 8-14 hours per day must receive an additional meal to meet a combined two-thirds of the recommended daily allowances. Modified diet menus should be provided where

	feasible and appropriate. Such modifications must take into consideration participant choice, health, religious and ethnic diet preferences. ▪ Recreation: Consisting of planned activities suited to the needs of the participant and designed to encourage physical exercise, maintain or restore abilities and skill, prevent deterioration, and stimulate social interaction. Each program may provide directly, or arrange for the provision of, the following optional services. If the program arranges for provision of any service at a place other than program-operated facilities, a written agreement specifying supervision requirements and responsibilities must be in place. ▪ Rehabilitative: Physical, occupational, speech, and hearing therapies provided by licensed professionals under order from a physician. ▪ Medical Support: Laboratory, x-ray, or pharmaceutical services provided by licensed professionals under order from a physician. ▪ Services within the scope of the Nursing Practice Act (PA 368 of 1978). ▪ Dental: Under the direction of a dentist. ▪ Podiatric: Provided or arranged for under the direction of a physician. ▪ Ophthalmologic: Provided or arranged for under the direction of an ophthalmologist. ▪ Health counseling. ▪ Shopping assistance/escort. Transportation between the participant's residence and the Adult Day Health center is provided when it is a standard component of the service. Not all Adult Day Health centers offer transportation to and from their facility. Additionally, some of those that offer transportation only offer this service in a specified area. When the center offers transportation, it is a component part of the Adult Day Health service. If the center does not offer transportation or does not offer it to the participant's residence, then MI Choice would pay for the transportation to and from the Adult Day Health center separately. If the provider operates its own vehicles for transporting participants to and from the program site, the provider must meet the following transportation minimum standards: ▪ All paid drivers must be physically capable and willing to assist persons requiring help to get in and out of vehicles. The provider must make such assistance available unless expressly prohibited by either a labor contract or an insurance policy. ▪ All paid drivers must be trained to cope with medical emergencies unless expressly prohibited by a labor contract. ▪ Each program must operate in compliance with PA 1 of 1985 regarding seat belt usage. A referral from a waiver agency for a MI Choice participant must replace any screening or assessment activities performed for other program participants. The adult day health service provider must accept copies of the MI Choice assessment and PCSP to eliminate duplicate assessment and service planning activities. Each program must establish written procedures (reviewed and approved by a consulting pharmacist, physician, or registered nurse) that govern the assistance

	given by staff to participants taking their own medications while participating in the program. The policies and procedures must minimally address: ▪ Written consent from the participant or participant's representative to assist in taking medications. ▪ Verification of the participant's medication regimen, including the prescriptions and dosages. ▪ The training and authority of staff to assist participants with taking their own prescribed or non-prescription medications and under what conditions such assistance may take place. ▪ Procedures for medication set-up. ▪ Secure storage of medications belonging to, and brought in by, participants. ▪ Disposal of unused medications for participants that no longer participate in the program. ▪ Instructions for entering medication information in participant files, including times and frequency of assistance. Each provider must employ a full-time program director with a minimum of a bachelor's degree in a health or human services field or be a qualified health professional. The provider must continually provide support staff at a ratio of no less than one staff person for every 10 participants. The provider may only provide health support services under the supervision of a registered nurse. If the program acquires either required or optional services from other individuals or organizations, the provider must maintain a written agreement that clearly specifies the terms of the arrangement between the provider and the other individual or organization. Staff must have basic first-aid training as well as other training as described in the Providers Section of this chapter. Each provider must have first-aid supplies available at the program site. The provider must make a staff person knowledgeable in first-aid procedures, including Cardiopulmonary Resuscitation (CPR), present at all times when participants are at the program site. Each provider must post procedures to follow in emergencies (fire, severe weather, etc.) in each room of the program site. Providers must conduct practice drills of emergency procedures once every six months. The program must maintain a record of all practice drills. The provider must maintain all equipment and furnishings used during program activities or by program participants in safe and functional condition. Each day care center must have the following furnishings: ▪ At least one straight back or sturdy folding chair for each participant and staff person. ▪ Lounge chairs or day beds as needed for naps and rest periods. ▪ Storage space for participants' personal belongings. ▪ Tables for both ambulatory and non-ambulatory participants. ▪ A telephone accessible to all participants. ▪ Special equipment as needed to assist persons with disabilities.

	Each day care center must document that it is in compliance with: ▪ Barrier-free design specifications of Michigan and local building codes. ▪ Fire safety standards. ▪ Applicable Michigan and local public health codes.
Limitations	Participants cannot receive Community Living Supports (CLS) while at the Adult Day Health center. Payment for Adult Day Health services includes all services provided while at the center. CLS may be used in conjunction with Adult Day Health services but cannot be provided at the exact same time. Participants must require regular supervision to live in their own homes or the homes of a relative. Participants with caregivers must require a substitute caregiver while their regular caregiver is at work, in need of respite, or otherwise unavailable. Participants must have difficulty performing activities of daily living (ADL) without assistance. Participants must be capable of leaving their residence with assistance to receive service. Participants are in need of intervention in the form of enrichment and opportunities for social activities to prevent or postpone deterioration that would likely lead to institutionalization. HCPCS codes S5101 and S5102 are limited to one unit per day.

4.1.B. Chore Services

Definition	Chore Services are needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, securing loose rugs and tiles, and moving heavy items of furniture in order to provide safe access and egress. Other covered services might include yard maintenance (mowing, raking and clearing hazardous debris such as fallen branches and trees) and snow plowing to provide safe access and egress outside the home. These types of services are allowed only in cases when neither the participant nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community or volunteer agency, or third party payer is capable of, or responsible for, their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.
Requirements	Waiver funds used to pay for chore services may include materials and disposable supplies used to complete the chore tasks. The waiver agency may also use waiver funds to purchase or rent the equipment or tools used to perform chore tasks for waiver participants. Only properly licensed suppliers may provide pest control services.

4.1.C. Community Health Worker

Definition	The Community Health Worker (CHW) works with participants who are re-enrolling in MI Choice, enrolling after a nursing facility or hospital discharge, or otherwise assists participants with obtaining access to community resources. The CHW may also perform the duties of a supports broker, providing assistance throughout the planning and implementation of the PCSP, assist the participant in making informed decisions about what works best for the participant, and assists with access to housing and employment. The CHW may offer practical skills training to enable participants to remain independent, including information for recruiting, hiring and managing workers

	as well as effective communication and problem solving. The CHW may also coach participants in managing health conditions, assist with scheduling appointments, facilitate coordination between various providers, and assist participants with completion of applications for programs for which they may be eligible. The CHW must work in close collaboration with the participant's Supports Coordinator as the Supports Coordinator has ultimate responsibility for the participant's case.
Requirements	The CHW service is not limited to nursing facility or hospital transitions. The service is available to any participant who may benefit from additional hands-on support to obtain assistance in the community. The CHW visits the participant at home within three days of hospital or facility discharge to review the discharge paperwork and any other documentation, reviews any medications received or orders that need to be filled, reminds the participant of the importance of filling the medications, and talks with the participant about the importance of following up with the physician. If needed, the CHW may make calls for medication to be filled, or to arrange for the follow-up appointment with the physician. The CHW also trains the participant about anything to be aware of and what to do if their condition worsens. The CHW does another follow-up visit within 30 days to determine whether the participant followed up with the physician, took the prescribed medications, and followed any other discharge recommendations. The CHW must thoroughly document what was discussed and discovered during the contacts with the participant so the Supports Coordinator is aware of what occurred. If there are medication discrepancies, the CHW will follow up with the RN Supports Coordinator to get those issues addressed. The CHW may also visit the individual in the nursing facility or hospital to ensure the staff knows who to contact to coordinate the discharge home. The CHW ensures the nursing facility or hospital staff has the contact of the Supports Coordinator with whom the discharge should be coordinated. If the Supports Coordinator wishes and the participant agrees, the CHW will be in contact with the nursing facility if a participant goes from a hospital to a nursing facility for temporary rehab before returning to the Waiver. The CHW may assist with coordinating any supplies, services, etc. the participant requires at home after rehabilitation. Providers for the CHW service may be unlicensed but must be trained in the duties of the job.

4.1.D. COMMUNITY LIVING SUPPORTS

Definition	Community Living Supports (CLS) facilitate an individual's independence and promote participation in the community. CLS can be provided in the participant's residence or in community settings. CLS includes assistance to enable participants to accomplish tasks that they would normally do for themselves if able. The services may be provided on an episodic or a continuing basis. The participant oversees and supervises individual providers on an ongoing basis when participating in self-determination options. These services are provided only in cases when neither the participant nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision.

Requirements	CLS includes: ▪ Assisting, reminding, cueing, observing, guiding and/or training in: ➢ Activities of Daily Living (ADL) such as bathing, eating, dressing, personal hygiene, toileting, transferring, etc. ***** ➢ Laundry and other household activities ➢ Non-medical care (not requiring nurse or physician intervention) * ➢ Meal preparation (does not include the cost of the meals themselves) ➢ Money management ➢ Shopping for food and other necessities of daily living ➢ Social participation, relationship maintenance, and building community connections to reduce personal isolation ➢ Training and assistance on activities that promote community participation such as using public transportation, using libraries, or volunteer work * ➢ Transportation from the participant's residence to medical appointments, community activities, among community activities, and from the community activities back to the participant's residence ➢ Routine, seasonal, and heavy household care and maintenance ➢ Attendance at medical appointments ➢ Participation in regular community activities incidental to meeting the individual's community living preferences ▪ Reminding, cueing, observing or monitoring of medication administration.***** ▪ Dementia care including, but not limited to, redirection, reminding, modeling, socialization activities, and activities that assist the participant as identified in the individual's PCSP.***** ▪ Staff assistance with preserving the health and safety of the participant in order that they may reside and be supported in the most integrated independent community setting.***** ▪ Observing and reporting any change in the participant's condition and the home environment to the supports coordinator.***** As applicable to the tasks being performed, the direct service provider furnishing CLS must have previous relevant experience or training and skills in housekeeping, household management, good health practices, observation, reporting, and recording information. Additionally, skills, knowledge, and experience with food preparation, safe food handling procedures, and reporting and identifying abuse and neglect are highly desirable. When the CLS services provided to the participant include tasks identified with an asterisk (*****) above, the direct service providers furnishing CLS must also: ▪ Be supervised by a RN licensed to practice nursing in Michigan. At the State's discretion, other qualified individuals may supervise CLS providers. For licensed residential settings, persons employed as facility owners or managers qualify to provide this supervision. The direct care worker's supervisor must be available to the worker at all times the worker is furnishing CLS services.

	▪ Develop in-service training plans and ensure all workers providing CLS services are confident and competent in the following areas before delivering CLS services to MI Choice participants, as applicable to the needs of that participant: safety, body mechanics, and food preparation including safe and sanitary food-handling procedures. ▪ Provide an RN to individually train and supervise CLS workers who perform higher-level, non-invasive tasks such as maintenance of catheters and feeding tubes, minor dressing changes, and wound care for each participant who requires such care. The supervising RN must ensure each worker's confidence and competence in the performance of each task required. ▪ MDHHS strongly recommends each worker delivering CLS services complete a certified nursing assistant (CNA) training course, first aid, and CPR training. When the CLS services provided to the participant include transportation, the following standards apply: ▪ Waiver agencies may not use waiver funds to purchase or lease vehicles for providing transportation services to waiver participants. ▪ All paid drivers for transportation providers supported entirely or in part by MI Choice funds must be physically capable and willing to assist persons requiring help to and from and to get in and out of vehicles. The provider must offer such assistance unless expressly prohibited by either a labor contract or insurance policy. ▪ The provider must train all paid drivers for transportation programs supported entirely or in part by MI Choice funds to cope with medical emergencies unless expressly prohibited by a labor contract or insurance policy. ▪ Each provider must operate in compliance with PA 1 of 1985 regarding seat belt usage. ▪ When transportation incidental to the provision of CLS is included, it shall not also be authorized as a separate waiver service for the participant. Individuals providing CLS must be at least 18 years old, and able to communicate effectively both orally and in writing and follow instructions. Members of a participant's family may provide CLS to the participant. However, waiver agencies must not directly authorize MI Choice funds to pay for services furnished to a participant by that person's spouse. Family members who provide CLS must meet the same standards as providers who are not related to the participant. The waiver agency or provider agency must train each worker to perform properly each task required for each participant the worker serves before delivering the service to that participant. The supervisor must ensure that each worker competently and confidently performs every task assigned for each participant served.

	Each direct service provider who chooses to allow staff to assist participants with self-medication must establish written procedures that govern the assistance given by staff to participants with self-medication. These procedures must be reviewed by a consulting pharmacist, physician, or RN and must include, at a minimum: ▪ The provider staff authorized to assist participants with taking their own prescription or over-the-counter medications and under what conditions such assistance may take place. This must include a review of the type of medication the participant takes and its impact upon the participant. ▪ Verification of prescription medications and their dosages. The participant must maintain all medications in their original, labeled containers. ▪ Instructions for entering medication information in participant files. ▪ A clear statement of the participant's and participant's family's responsibility regarding medications taken by the participant and the provision for informing the participant and the participant's family of the provider's procedures and responsibilities regarding assisted self-administration of medications. CLS providers may only administer medications in compliance with Michigan Administrative Rule 330.7158: ▪ A provider must only administer medication at the order of a physician and in compliance with the provisions of section 719 of the act, if applicable. ▪ A provider must ensure that medication use conforms to federal standards and the standards of the medical community. ▪ A provider must not use medication as punishment, for the convenience of the staff, or as a substitute for other appropriate treatment. ▪ A provider must review the administration of a psychotropic medication periodically as set forth in the participant's PCSP and based upon the participant's clinical status. ▪ If a participant cannot administer their own medication, a provider must ensure that medication is administered by or under the supervision of personnel who are qualified and trained. ▪ A provider must record the administration of all medication in participant's clinical record. ▪ A provider must ensure that staff report medication errors and adverse drug reactions to the participant's physician immediately and properly, and record the incident in the participant's clinical record. CLS provided in a residential setting like assisted living, Adult Foster Care, or Homes for the Aged, includes only those services and supports that are in addition to, and must not replace, usual and customary supports and services furnished to residents in the licensed setting. CLS does not include the costs associated with room and board. Documentation in the participant's record must clearly identify the participant's need for additional supports and services not covered by licensure. The PCSP must clearly identify the portion of the participant's supports and services covered by CLS. Homemaking tasks incidental to the provision of assistance with ADL may also be included in CLS but must not replace usual and customary homemaking tasks required by licensure. When CLS services are provided to the participant under a self-determination arrangement, the individual furnishing CLS must also be trained in cardiopulmonary

	resuscitation. This training may be waived when the provider is furnishing services to a participant who has a "Do Not Resuscitate" order. These service needs differ in scope, nature, supervision arrangements, or provider type (including provider training and qualifications) from services available in the State Plan. The differences between the waiver coverage and the State Plan are that the provider qualifications and training requirements are more stringent for CLS tasks as provided under the waiver than the requirements for these types of services under the State Plan.
Limitations	CLS does not include the costs associated with room and board. When transportation incidental to the provision of CLS is included, the waiver agency must not also authorize transportation as a separate waiver service for the participant. CLS excludes nursing and skilled therapy services. The phrase "These services are provided only in cases when neither the participant nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision" included in the definition of this service shall be interpreted as follows: ▪ All informal supports must agree to provide the uncompensated (informal) services and supports to the participant as specified in the PCSP. Specifically, the record must show the following: ➢ All persons providing informal services and supports included on the PCSP are aware of and capable of performing the tasks assigned to them for the benefit of the participant as included in the person-centered service plan. ➢ All informal supports agree to any financial liability related to the informal services and supports assigned to them on the person-centered service plan. This includes uncompensated or voluntary transportation of the participant. ➢ Supports coordinators or other waiver agency staff did not arbitrarily assign the completion of services and supports that could otherwise be included as CLS to informal supporters. Rather, both the participant (or their responsible party) and the informal support agree in writing (by their signature on the person-centered service plan) to the provision of the identified services and supports as discussed during a person-centered planning meeting. Relatives, caregivers, landlords, community or volunteer agencies, or other third-party payers have been contacted on behalf of the participant and agree to provide services and supports to the participant because they are both capable of and responsible for the provision of the identified services and supports. This agreement is noted by an authorized signature on the person-centered service plan from a representative of the entity identified as responsible for the services and supports.

4.1.E. COMMUNITY TRANSPORTATION

Definition	Community transportation (CT) service includes both non-emergency medical transportation and non-medical transportation. Community transportation services are offered to enable waiver participants to access waiver services and other community services, activities, and resources as specified in

	the person-centered service plan. The community transportation service may also include expenses related to transportation and other travel expenses determined necessary to secure medical examinations, appointments, documentation, or treatment for participants.
Requirements	Waiver agencies will ensure MI Choice participants have access to community transportation as needed to obtain medical services. Utilization of family, friends, or community agencies who provide transportation services without charge must be explored before MI Choice will authorize community transportation. Community transportation services include, but are not limited to, transportation to obtain the following medical services: ▪ Chronic and ongoing treatment; ▪ Prescriptions; ▪ Medical supplies and devices; ▪ One-time, occasional and ongoing visits for medical care; and ▪ Services received at a Veterans' Affairs hospital. Travel expenses related to the provision of community transportation include: ▪ The cost of transportation for the MI Choice participant by wheelchair vans, taxis, bus passes and tickets, secured transportation containing an occupant protection system that addresses safety needs of disabled or special needs individuals, and other forms of transportation; ▪ Mileage reimbursement for individuals or volunteers with a valid driver's license utilizing personal vehicles to transport the MI Choice participant; ▪ The cost of meals and lodging en route to and from medical care, and while receiving medical care; ▪ The cost of an attendant to accompany the MI Choice participant, if necessary; ▪ The cost of the attendant's transportation, meals, and lodging when transporting to or from medical care; and ▪ The attendant's salary if the attendant is not a volunteer or a member of the MI Choice participant's family who is not already a paid caregiver. Delivery services for medical items, such as medical supplies or prescriptions, should be utilized before authorizing community transportation services through the MI Choice program. When authorizing CT, waiver agencies are to authorize the least expensive available means suitable to the participant's needs. Waiver agencies may only authorize CT to provide transportation assistance to the participant. The participant must travel away from home to other locations within the community. CT does not include reimbursement for caregivers of the participant to run errands or otherwise travel on behalf of the participant. Each provider must operate in compliance with PA 1 of 1985 regarding seat belt usage unless the provider is a volunteer driver only seeking mileage reimbursement. Additionally, delivery services for medical items, such as medical supplies or prescriptions, should be utilized before authorizing CT through the MI Choice program.

	Waiver agencies must use the SC modifier when billing for ancillary items that are only available for specific medically-related travel. This includes meals (A0190, A0210), lodging (A0180, A0200), and waiting time for air ambulances and non-emergency vehicles (T2007). Waiver agencies may utilize a process to prior authorize requests for the following: ▪ All outstate travel that is non-borderland for medical treatment. ▪ Overnight stays if within 50 miles one-way from the participant's home for medical treatment. ▪ Overnight stays beyond five nights, including meals and lodging, when traveling for medical treatment. ▪ An attendant in addition to the driver of a wheelchair lift/medivan vehicle. ▪ Mileage and meal expenses for daily long-distance trips for medical treatment.
Limitations	When the costs of transportation are included in the provider rate for another waiver service (e.g., Adult Day Health or CLS), there must be mechanisms to prevent the duplicative billing of CT. Waiver agencies must not authorize MI Choice CT services to reimburse caregivers (paid or informal) to run errands for participants when the participant does not accompany the driver in the vehicle. The purpose of the CT service is to enable MI Choice participants to gain access to medical services and community activities/outings. Reimbursement for CT **DOES NOT** include the following: ▪ Waiting time, unless for an air ambulance or non-emergency vehicle. ➢ Waiting times may be covered if built into the transportation reimbursement rate. Waiting times are also covered if the participant cannot wait for the transportation vehicle after outings due to medical conditions (i.e., cannot stay in wheelchair for long periods of time due to swelling or pain, etc.). ▪ Transportation for medical services that have already been provided. ▪ Transportation costs to meet a participant's personal choice of provider for routine medical care outside the community when comparable care is available locally. Participants are encouraged to obtain medical care in their own community unless referred elsewhere by their local health care professional. ▪ Reimbursement for meals or lodging when the purpose of travel is not related to the receipt of Medicaid-covered medical services. Meals and lodging are only reimbursed when the participant and attendant are traveling to seek Medicaid-covered medical services. All paid drivers for transportation providers supported entirely or in part by MI Choice funds must be physically capable and willing to assist persons requiring help to and from and to get in and out of vehicles. The provider must offer such assistance unless expressly prohibited by either a labor contract or insurance policy. The provider must train all paid drivers for transportation programs supported entirely or in part by MI Choice funds to cope with medical emergencies, unless expressly prohibited by a labor contract or insurance policy.

4.1.F. Counseling

Definition	Counseling services seek to improve the participant's emotional and social well-being through the resolution of personal problems or through changes in a participant's social situation.
Requirements	Counseling services must be directed to participants who are experiencing emotional distress or a diminished ability to function. Family members, including children, spouses or other responsible relatives, may participate in the counseling session to address and resolve the problems experienced by the participant and to prevent future issues from arising. Counseling services are typically provided on a short-term basis to address issues such as adjusting to a disability, adjusting to community living, and maintaining or building family support for community living. Counseling services are not intended to address long-term behavioral or mental health needs. Providers receiving waiver funds for counseling services must provide the following service components, at a minimum: ▪ Psychosocial evaluation to determine appropriateness of counseling options. ▪ Treatment plan that states goals and objectives, and projects the frequency and duration of service. ▪ Individual, family, and/or group counseling sessions. ▪ Home visits and on-site counseling. ▪ Case conferencing with a waiver supports coordinator at least once every six weeks with participant's release. Persons providing counseling services must: ▪ Have a master's degree or higher in social work, psychology, psychiatric nursing, or counseling, or ▪ Have a bachelor's degree in one of the above areas and be under the supervision of a mental health professional with a master's degree or higher, AND ▪ Be licensed in the State of Michigan.

4.1.G. Environmental Accessibility Adaptations

Definition	Environmental Accessibility Adaptations (EAA) include physical adaptations to the home required by the participant's person-centered service plan that are necessary to ensure the health and welfare of the participant or that enable the participant to function with greater independence in the home, without which the participant would require institutionalization.
Requirements	Adaptations may include: ▪ Installation of ramps and grab bars; ▪ Widening of doorways; ▪ Modification of bathroom facilities; ▪ Modification of kitchen facilities;

	▪ Installation of specialized electrical and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the participant; and ▪ Environmental control devices that replace the need for paid staff and increase the participant's ability to live independently, such as automatic door openers. Assessments and specialized training needed in conjunction with the use of such environmental adaptations are included as a part of the cost of the service. The case record must contain documented evidence that the adaptation is the most cost-effective and reasonable alternative to meet the participant's need(s). An example of a reasonable alternative, based on the results of a review of all options, may include changing the purpose, use or function of a room within the home or finding alternative housing. The participant must agree to the reasonable alternative prior to starting the modifications. Environmental adaptations required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for safe operation of the specified equipment and are not intended to correct existing code violations in a participant's home. The waiver agency must ensure there is a signed contract or bid proposal with the licensed builder or contractor prior to the start of an environmental adaptation. It is the responsibility of the waiver agency to work with the participant and the licensed builder or contractor to ensure the work is completed as outlined in the contract or bid proposal. The waiver agency must document approval of all EAA in the participant's record. This documentation must minimally include dates, tasks performed, materials used, and cost. All services must be provided in accordance with applicable state or local building codes. The existing structure must have the capability to accept and support the proposed changes. The environmental adaptation must incorporate reasonable and necessary construction standards, excluding cosmetic improvements. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values. Under the EAA service, waiver agencies may use MI Choice funds to purchase materials and labor used to complete the modifications to prevent or remedy a sub-standard condition or safety hazard. The direct service provider must provide equipment or tools needed to perform modifications or adaptations unless another source can provide the tools or equipment at a lower cost or free of charge and the provider agrees to use such equipment or tools. The waiver agency may purchase supplies for the modification or adaptation, such as grab bars, lumber, or plumbing supplies, and provide them to the direct service provider at their discretion. The participant, with the direct assistance of the waiver agency's supports coordinator when necessary, must make a reasonable effort to access all available funding sources such as housing commission grants, Michigan State Housing Development Authority (MSHDA), and community development block grants. Before approving MI Choice payment for each modification or adaptation, each waiver agency must determine whether a participant is eligible to receive services through a program supported by other funding sources. The participant's case record must include

	evidence of efforts to apply for alternative funding sources and the acceptances or denials of these funding sources. Adaptations may be made to rental properties when the lease or rental agreement does not indicate that the landowner is responsible for such adaptations and the landowner agrees to the adaptation in writing. A written agreement between the landowner, the participant, and the waiver agency must specify any requirements for restoration of the property to its original condition if the occupant moves. Providers of EAA must be licensed in the State of Michigan.
Limitations	Excluded are those adaptations or improvements to the home that: ▪ Are of general utility. ▪ Are considered to be standard housing obligations of the participant or homeowner. ▪ Are not of direct medical or remedial benefit. Examples of exclusions include, but are not limited to: ▪ Carpeting ▪ Roof repair ▪ Sidewalks and driveways ▪ Heating ▪ Central air conditioning (except under exceptions noted in the service definition) ▪ Garages and raised garage doors ▪ Storage and organizers ▪ Hot tubs, whirlpool tubs, and swimming pools ▪ Landscaping ▪ General home repairs MI Choice does not cover general construction costs in a new home or additions to a home purchased after the participant is enrolled in the waiver. If a participant or the participant's family purchases or builds a home while receiving waiver services, it is the participant's or family's responsibility to ensure the home will meet basic needs, such as having a ground floor bath or bedroom if the participant has mobility limitations. MI Choice funds may be authorized to assist with the adaptations noted above (e.g., ramps, grab bars, widening doorways, bathroom modifications, etc.) for a home recently purchased. If modifications are needed to a home under construction that require special adaptation to the plan (e.g., roll-in shower), the MI Choice program may be used to fund the difference between the standard fixture and the modification required to accommodate the participant's need. The infrastructure of the home involved in the funded adaptations (e.g., electrical system, plumbing, well or septic, foundation, heating and cooling, smoke detector systems, or roof) must be in compliance with any applicable local codes. Environmental adaptations shall exclude costs for improvements exclusively required to meet applicable state or local building codes. The existing structure must have the capability to accept and support the proposed changes.

4.1.H. Fiscal Intermediary

Definition	Fiscal Intermediary (FI) services assist participants who choose the self-determination option in acquiring and maintaining services defined in the participant's person-centered service plan, controlling a participant's budget, and choosing staff authorized by the waiver agency. The Fiscal Intermediary helps a participant manage and distribute funds contained in an individual budget. Funds are used to purchase waiver goods and services authorized in the participant's person-centered service plan. Fiscal Intermediary services include, but are not limited to, the facilitation of the employment of MI Choice service providers by the participant (including federal, state, and local tax withholding or payments, unemployment compensation fees, wage settlements), fiscal accounting, tracking and monitoring participant-directed budget expenditures and identifying potential over- and under-expenditures, and ensuring compliance with documentation requirements related to management of public funds. The Fiscal Intermediary may also perform other supportive functions that enable the participant to self-direct needed services and supports. These functions may include verification of provider qualifications, including reference and criminal history reviews, and assisting the participant to understand billing and documentation requirements.
Requirements	Each FI must be bonded and insured. The insured amount must exceed the total budgetary amount the FI is responsible for administering. Each FI must demonstrate the ability to manage budgets and perform all functions of the FI, including all activities related to employment taxation, worker's compensation, and state, local, and federal regulations. Each FI must demonstrate competence in managing budgets and performing other functions and responsibilities of a fiscal intermediary. Each FI will provide four basic areas of performance: ▪ Function as the employer agency for participants directly employing workers to ensure compliance with payroll tax and insurance requirements; ▪ Ensure compliance with requirements related to management of public funds, the direct employment of workers by participants, and contracting for other authorized goods and services; ▪ Facilitate successful implementation of the self-determination arrangements by monitoring the use of the budget and providing monthly budget status reports to each participant and waiver agency; and ▪ Offer supportive services to enable participants to self-determine and direct the services and supports they need. The waiver agency and FI must abide by the principles set forth in the Self-Determination Technical Advisory "Choice Voucher System" available in the Directory Appendix. Participants choosing self-determination and utilizing the Agency with Choice option do not have to utilize a fiscal intermediary. Participants using the Agency with Choice option may choose to have the agency perform the four basic areas of performance outlined above.

Limitations	FI services are only available to those participants choosing the self-determination option for service delivery. Providers of other covered services to the participant, family, or guardians of the participant may not provide FI services to the participant.

4.1.I. Goods and Services

Definition	Goods and Services are services, equipment or supplies not otherwise provided through either the MI Choice Waiver or the State Plan that address an identified need in the person-centered service plan (including improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements.
Requirements	Each item or service specified in the PCSP must meet the following requirements: ▪ Decrease the need for other Medicaid services. ▪ Promote inclusion in the community. ▪ Increase the participant's safety in the home environment. ▪ The participant does not have the funds to purchase them or they are not available through another source. Goods and Services are only approved by CMS for participants choosing the self-determination option. Self-directed Goods and Services are purchased from the participant-directed budget. Experimental or prohibited treatments are excluded. Goods and Services must be documented in the person-centered service plan.
Limitations	This service is only available to those participants choosing self-determination. This service excludes experimental or prohibited treatments.

4.1.J. Home Delivered Meals

Definition	Home Delivered Meals (HDM) is the provision of one to two nutritionally sound meals per day to a participant who is unable to care for their own nutritional needs. The unit of service is one meal delivered to the participant's home or to the participant's selected congregate meal site that provides a minimum of one-third of the current recommended dietary allowance (RDA) for the age group as established by the Food and Nutritional Board of the National Research Council of the National Academy of Sciences. Allowances must be made in HDMs for specialized or therapeutic diets as indicated in the person-centered service plan. A HDM cannot constitute a full nutritional regimen.
Requirements	Each waiver agency must have written eligibility criteria for persons receiving home delivered or congregate meals authorized through the waiver program which include, at a minimum: ▪ The participant must be unable to consistently obtain food or prepare complete meals. ▪ The participant does not have an adult living at the same residence or in the vicinity who is able and willing to prepare all meals. ▪ The participant does not have a paid caregiver who is able and willing to prepare meals for the participant.

	▪ The provider can appropriately meet the participant's special dietary needs, and the meals available will not jeopardize the participant's health. ▪ The participant must be able to feed themself. ▪ The participant must agree to be home when meals are delivered, or contact the program when an absence is unavoidable. Federal regulations prohibit the MI Choice program from providing three meals per day to waiver participants. Providers must vary the level of meal service for an individual in response to varying availability of help from allies and formal caregivers, and changes in the participant's status or condition. When MI Choice provides home delivered meals less than seven days per week, the waiver agency must identify and document in the case record the usual source of all meals for the participant that are not provided by the program. HDM providers and waiver agencies must follow the home delivered meals guidelines provided in the Directory Appendix. When developing menus, MDHHS encourages every attempt to include key nutrients and to follow other dietary recommendations that relate to lessening chronic disease and improving the health of MI Choice participants. Diabetes, hypertension, and obesity are three prevalent chronic conditions among all adults in Michigan. Providers should pay special attention to nutritional factors that can help prevent and manage these and other chronic conditions. Providers must use person-centered planning principles when doing menu planning. Examples of person-centered menu planning include offering rather than serving food and providing choices of food as often as possible. Key recommendations from the United States Department of Agriculture (USDA) Dietary Guidelines for Americans (DGA) should be considered when planning meals and minimally contain 33 1/3 percent of the current DRI as established by the Food and Nutrition Board of the National Academy of Science, National Research Council. Each provider must have written policies and procedures that integrate person-centered planning into the home delivered and congregate meals program. This includes allowing participants to attend congregate meals sites when they have transportation or help to the site and providing diet modifications, as requested by the participant when the provider is able to do so while following established nutritional guidelines. Each home delivered or congregate meals provider must have the capacity to provide three meals per day, which together meet the dietary reference intake (DRI) as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences. Each provider must have meals available at least five days per week. The provider may offer liquid meals to participants when ordered by a physician. The regional dietitian must approve all liquid meals products used by the provider. The provider or supports coordinator must provide instruction to the participant, the participant's caregiver, and participant's family in the proper care and handling of liquid meals. The waiver agency and provider must meet the following requirements when liquid meals are the sole source of nutrition: ▪ Diet orders must include participant weight and specify the required nutritional content of the liquid meals. ▪ The supports coordinator must ensure the participant's physician renews the diet orders every three months, and

	▪ The MI Choice RN supports coordinator and participant must develop the PCSP for participant receiving liquid meals in consultation with the participant's physician. The provider may supply liquid nutritional supplements ordered by a supports coordinator where feasible and appropriate. When liquid nutrition supplements a participant's diet, the supports coordinator must ensure the physician renews the order for liquid nutritional supplements every six months. However, liquid nutritional supplements are classified as a specialized medical supply for purposes of the MI Choice program and must be billed accordingly. The supports coordinator or provider must verify and maintain records that indicate each participant can provide safe conditions for the storage, thawing, and reheating of frozen foods. Frozen foods should be kept frozen at 0 degrees Fahrenheit thawing for consumption. Unless otherwise preferred by the participant, providers must not furnish more than a two-week supply of frozen meals to a participant during one home delivery visit. Each provider must develop and have available written plans for continuing services in emergencies such as short-term natural disasters (e.g., snow and/or ice storms), loss of power, physical plant malfunctions, etc. The provider must train staff and volunteers on procedures to follow in the event of severe weather or natural disasters and the county emergency plan. The emergency plan shall address, but not be limited to: ▪ Uninterrupted delivery of meals to HDM participants, including, but not limited to use of families and friends, volunteers, shelf-stable meals and informal support systems; ▪ Provision of at least two, and preferably more, shelf-stable meals and instructions on how to use for participants. Every effort should be made to assure that the emergency shelf-stable meals meet the nutrition guidelines. If it is not possible, shelf-stable meals will not be required to adhere to the guidelines. ▪ MI Choice participants may receive two emergency meals. ▪ Back-up plan for food preparation if usual kitchen facility is unavailable; ▪ Agreements in place with volunteer agencies, individual volunteers, hospitals, long-term care facilities, other nutrition providers, or other agencies/groups that could be on standby to assist with food acquisition, meal preparation, and delivery; ▪ Communications system to alert congregate and home-delivered meals participants of changes in meal site/delivery; ▪ The plan shall cover all the sites and participants for each provider, including sub-contractors of the provider. A record of the menu actually served each day shall be maintained for each fiscal year's operation. Monthly nutrition education sessions must be offered at each meal site and as appropriate to home-delivered meal participants. Emphasis should focus on giving the participant the information and tools to make food choices in relation to health and wellness, and to any chronic diseases they may have, including making choices at the meal site, at home, and when they eat out.

	Topics shall include, but not be limited to, food, nutrition, and wellness issues. Nutrition education materials must come from reputable sources. Questions pertaining to appropriateness of materials and presenters are to be directed to the staff dietitian, regional dietitian or Dietetic Technician, Registered (DTR). Program materials distributed must take into consideration the level of literacy, living alone status, caregiver support and translation of materials as appropriate for older adults with limited English proficiency. At least once per year, the following topics must be covered: ▪ How food choices affect chronic illnesses ▪ Food safety at home and when dining out ▪ Food choices at home ▪ Emergency preparedness- what to have on hand Each provider must operate according to the Michigan Food Code and must have a copy of the most recent version of the Code available for reference. Complaints from participants should be referred to the provider that hosts the site or manages the HDMs. Each provider shall have a written procedure for handling complaints. The provider and waiver agency must develop a plan for what type of complaints need to be referred to the waiver agency. Home Visit Safety. Assessors, HDM drivers, delivery people and other staff are not expected to be placed in situations that they feel unsafe or threatened. Providers must work with their waiver agency to create a "Home Visit Safety Policy" that addresses verbal and physical threats made to the assessor(s), drivers or other program persons, by participants, family members, pets (animals) or others in the home during the assessment. This policy should include, but is not limited to: ▪ Definition of a verbal or physical threat; ▪ How a report should be made/who investigates the report; ▪ What actions should be taken by the assessor or driver if they are threatened; ▪ What warnings should be given to the participant; ▪ What actions should be taken for repeated behaviors; ▪ What information gets recorded in the chart; and ▪ Situations requiring multiple staff/volunteers.
Limitations	The meals authorized under this service must not constitute a full nutritional regimen. Providers must not solicit donations from waiver participants. Providers must not use waiver funds to purchase dietary supplements such as vitamins and minerals. When the participant has informal supports or paid caregivers available during meal times, the case record must clearly document the need for a home delivered meal.

4.1.K. Nursing Services

Definition	Nursing Services are covered on an intermittent (separated intervals of time) basis for a participant who requires nursing services for the management of a chronic illness or physical disorder in the participant's home. These services are provided by a

	registered nurse (RN) or a licensed practical nurse (LPN) under the direct supervision of an RN. Nursing Services are for participants who require more periodic or intermittent nursing than available through the State Plan or third party payer resources for the purpose of preventive interventions to reduce the occurrence of adverse outcomes for the participant, such as hospitalizations and nursing facility admissions.
Requirements	When the participant's condition is unstable, could easily deteriorate, or significantly changes, MI Choice covers nurse visits for observation and evaluation. The purpose of the observation and evaluation is to monitor the participant's condition and report findings to the participant's physician or other appropriate health professional to prevent additional decline, illness, or injury to the participant. The supports coordinator must communicate with both the nurse providing this service and the participant's health professional to ensure the nursing needs of the participant are being addressed. Participants must meet at least one of the following criteria to qualify for this service: ▪ Be at high risk of developing skin ulcers or have a history of resolved skin ulcers that could easily redevelop. ▪ Require professional monitoring of vital signs when changes may indicate the need for modifications to the medication regimen. ▪ Require professional monitoring or oversight of blood sugar levels, including participant-recorded blood sugar levels, to assist with effective pre-diabetes or diabetes management. ▪ Require professional assessment of the participant's cognitive status or alertness and orientation to encourage optimal cognitive status and mental function, or identify the need for modifications to the medication regimen. ▪ Require professional evaluation of the participant's success with a prescribed exercise routine to ensure its effectiveness and identify the need for additional instruction or modifications when necessary. ▪ Require professional evaluation of the participant's physical status to encourage optimal functioning and discourage adverse outcomes. ▪ Have a condition that is unstable, could easily deteriorate, or experience significant changes AND a lack of competent informal supports able to readily report life-threatening changes to the participant's physician or other appropriate health professional. In addition to the observation and evaluation, a nursing visit may also include, but is not limited to, one or more of the following nursing services: ▪ Administering prescribed medications that cannot be self-administered (as defined under Michigan Compiled Law (MCL) 333.7103(1)). ▪ Setting up medications according to physician orders. ▪ Monitoring participant's adherence to their medication regimen. ▪ Applying dressings that require prescribed medications and aseptic techniques. ▪ Providing refresher training to the participant or informal caregivers to ensure the use of proper techniques for health-related tasks such as diet, exercise regimens, body positioning, taking medications according to physician's orders, proper use of medical equipment, performing ADL, or safe ambulation within the home.

Limitations	This service is limited to no more than two hours per visit unless a reason for a longer visit is clearly documented in the participant's record (such as requiring three hours to complete a complicated dressing change). Participants receiving Private Duty Nursing/Respiratory Care services are not eligible to receive MI Choice Nursing Services. All providers furnishing this service must be licensed as either a Registered Nurse or a Licensed Practical Nurse in the State of Michigan.

4.1.L. PERSONAL EMERGENCY RESPONSE SYSTEM

Definition	A Personal Emergency Response System (PERS) is an electronic device that enables a participant to summon help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is often connected to the participant's phone and programmed to signal a response center once a "help" button is activated. Installation, upkeep and maintenance of devices and systems are also provided.
Requirements	The provider may offer this service for cellular or mobile phones and devices. The device must meet industry standards. The participant must reside in an area where the cellular or mobile coverage is reliable. When the participant uses the device to signal and otherwise communicate with the PERS provider, the technology for the response system must meet all other service standards. The response center must maintain the monitoring capacity to respond to all incoming emergency signals 24 hours per day, 365 days per year. The response center will provide accommodations for persons with limited English proficiency. The response center must have the ability to accept multiple signals simultaneously. The response center must not disconnect calls for a return call or put in a first call, first serve basis. The provider will furnish each responder with written instructions and provide training, as appropriate. The provider will verify the responder and contact names for each participant on a semi-annual basis to ensure current and continued participation. The provider will ensure at least monthly testing of each PERS unit to ensure continued functioning. The provider will furnish ongoing assistance, as necessary, to evaluate and adjust the PERS instrument or to instruct participants and caregivers in the use of the devices, as well as to provide performance checks. The provider will maintain individual client records that include the following: ▪ Service order, ▪ Record of service delivery, including documentation of delivery and installation of equipment, participant/caregiver orientation, and monthly testing, ▪ List of emergency responders for each participant, and ▪ A case log documenting participant and responder contacts. The Federal Communication Commission must approve the equipment used for the response system. The equipment must meet UL® safety standards 1637 specifications for Home Health Signaling Equipment.

Limitations	PERS does not cover monthly telephone charges associated with phone service. PERS is limited to persons who either live alone or who are left alone for significant periods on a routine basis and who could not summon help in an emergency without this device. Waiver agencies may authorize PERS units for persons who do not live alone if both the participant and the person with whom they reside would require extensive routine supervision without a PERS unit in the home. The supports coordinator must clearly document in the case record the reason for provision of a PERS. Waiver agencies may provide a purchased unit like a PERS device. This type of unit does not require an installation or monthly fee but is a one-time cost. These units are covered under the Specialized Medical Equipment and Supplies service. Participants should not have both a purchased and a rented unit.

4.1.M. PRIVATE DUTY NURSING/RESPIRATORY CARE

Definition	Private Duty Nursing/Respiratory Care (PDN/RC) services are skilled nursing or respiratory care interventions provided to a participant age 21 and older on an individual and continuous basis to meet health needs directly related to the participant's physical disorder. PDN/RC includes the provision of skilled assessment, treatment, and observation provided by licensed nurses within the scope of the State's Nurse Practice Act, consistent with physician's orders and in accordance with the participant's person-centered service plan. RC may be provided by a licensed respiratory therapist to a participant who is ventilator dependent. To be eligible for PDN/RC services, the waiver agency must find the participant meets either Medical Criteria I or Medical Criteria II, and Medical Criteria III. Regardless of whether the participant meets Medical Criteria I or II, the participant must also meet Medical Criteria III. The participant's PCSP must provide reasonable assurance of participant safety. This includes a strategy for effective backup in the event of an absence of providers. The backup strategy must include informal supports or the participant's capacity to manage their care and summon assistance. PDN/RC for a participant between the ages of 18-21 is covered under the State Plan.
Requirements	Through a person-centered planning process, the waiver agency must determine the length and duration of services provided. The direct service provider must maintain close contact with the authorizing waiver agency to promptly report changes in each participant's condition and/or treatment needs upon observation of such changes. The direct service provider must send case notes to the supports coordinator on a regular basis, preferably monthly, but no less than quarterly, to update the supports coordinator on the condition of the participant. This service may include medication administration as defined under Michigan law. The waiver agency is responsible for assuring there is a physician order for the PDN services authorized. The physician may issue this order directly to the provider furnishing PDN/RC services. However, the waiver agency is responsible for assuring the PDN/RC provider has a copy of these orders and delivers PDN/RC services according to the orders. The waiver agency must maintain a copy of the physician orders in the case record.

Medical Criteria	To be eligible for PDN/RC services, the waiver agency must find the participant meets either Medical Criteria I or Medical Criteria II, and Medical Criteria III. Regardless of whether the participant meets Medical Criteria I or II, the participant must also meet Medical Criteria III. **Medical Criteria I** – The participant is dependent daily on technology-based medical equipment to sustain life. "Dependent daily on technology-based medical equipment" means: ▪ Mechanical rate-dependent ventilation (four or more hours per day) or assisted rate-dependent respiration (e.g., some models of bi-level positive airway pressure [Bi-PAP]); or ▪ Deep oral (past the tonsils) or tracheostomy suctioning eight or more times in a 24-hour period; or ▪ Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; or ▪ Total parenteral nutrition delivered via a central line, associated with complex medical problems or medical fragility; or ▪ Continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter and a documented need for skilled assessment, judgment, and intervention in the rate of oxygen administration. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for beneficiaries age 21 and older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below, or the P02 level is 55 mm HG or below. **Medical Criteria II** – Frequent episodes of medical instability within the past three to six months requiring skilled assessments, judgments, or interventions (as described in III below) as a result of a substantiated medical condition directly related to the physical disorder. Definitions of Medical Criteria II: ▪ "Frequent" means at least 12 episodes of medical instability related to the progressively debilitating physical disorder within the past six months, or at least six episodes of medical instability related to the progressively debilitating physical disorder within the past three months. ▪ "Medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder. ▪ "Emergency medical treatment" means covered inpatient and outpatient services that are furnished by a provider who is qualified to furnish such services and that are needed to evaluate or stabilize an emergency medical condition. ▪ "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention would result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

	▪ "Directly related to the physical disorder" means an illness, diagnosis, physical impairment, or syndrome that is likely to continue indefinitely, and results in significant functional limitations in three or more ADL. ▪ "Substantiated" means documented in the clinical or medical record, including the progress notes. **Medical Criteria III** – The participant requires continuous skilled care on a daily basis during the time when a licensed nurse or respiratory therapist is paid to provide services. Definitions of Medical Criteria III: ▪ "Continuous" means at least once every three hours throughout a 24-hour period, and when delayed interventions may result in further deterioration of health status, in loss of function or death, in acceleration of the chronic condition, or in a preventable acute episode. ▪ Equipment needs alone do not create the need for skilled services. ▪ "Skilled" means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse or respiratory therapist. Skilled care includes, but is not limited to: ➢ Performing assessments to determine the basis for acting or a need for action, and documentation to support the frequency and scope of those decisions or actions. ➢ Managing mechanical rate-dependent ventilation or assisted rate-dependent respiration (e.g., some models of Bi-PAP) that is required by the participant four or more hours per day. ➢ Deep oral (past the tonsils) or tracheostomy suctioning. ➢ Injections when there is a regular or predicted schedule, or prn injections that are required at least once per month (insulin administration is not considered a skilled intervention). ➢ Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility. ➢ Total parenteral nutrition delivered via a central line and care of the central line. ➢ Continuous oxygen administration (eight or more hours per day) in combination with a pulse oximeter, and a documented need for adjustments in the rate of oxygen administration requiring skilled assessments, judgments and interventions. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for beneficiaries age 21 and older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below, or the P02 level is 55 mm HG or below. ➢ Monitoring fluid and electrolyte balances where imbalances may occur rapidly due to complex medical problems or medical fragility. Monitoring by a skilled nurse would include maintaining strict intake and output, monitoring skin for edema or dehydration, and watching for cardiac and respiratory signs and symptoms.

	➢ Taking routine blood pressure and pulse once per shift that does not require any skilled assessment, judgment or intervention at least once every three hours during a 24-hour period, as documented in the nursing notes, would not be considered skilled nursing.
Limitations	Participants receiving MI Choice Nursing Services are not eligible to receive PDN/RC services. All PDN/RC services authorized must be medically necessary as indicated through the MI Choice assessment and meet the medical criteria described above. The participant's physician, physician assistant, or nurse practitioner must order PDN/RC services and work in conjunction with the waiver agency and provider agency to ensure services are delivered according to that order. Orders should be updated on an annual basis unless the order states otherwise due to ongoing medical need that is unlikely to improve over time. PDN is limited to persons age 21 or older. PDN is a State Plan benefit for persons under the age of 21 who qualify for the service. It is not the intent of the MI Choice program to provide PDN/RC services on a continual 24-hours-per-day/7-days-per-week basis. MI Choice services are intended to supplement informal support services available to the participant. Only under extreme circumstances should 24/7 PDN/RC be authorized for a participant. These circumstances must be clearly described on the person-centered service plan and approved by MDHHS. PDN/RC services provided 24/7 cannot be authorized for participants who cannot direct their own services and supports, make informed decisions for themselves, or engage their emergency backup plan without assistance. These participants must have informal caregivers actively involved in providing some level of direct services to them on a routine basis. A need for 24/7 PDN/RC cannot be used as a primary reason for denying MI Choice eligibility or enrollment as there are circumstances when 24/7 PDN/RC may be appropriate for MI Choice participants. For all individuals requiring 24/7 PDN/RC, an assessment, person-centered service plan, backup/contingency plan, and order from a medical professional must be submitted to MDHHS for review and decision. Providers of PDN/RC must be licensed by the State of Michigan.

4.1.N. RESPITE

Definition	Respite services are provided to participants unable to care for themselves and are furnished on a short-term basis due to the absence of, or need of relief for, those unpaid individuals normally providing services and supports for the participant. Respite services may be provided in the participant's home, in the home of another, or in a Medicaid-certified hospital, nursing facility, or a licensed Adult Foster Care (AFC) facility. Respite does not include the cost of room and board, except when provided as part of respite furnished in a facility approved by MDHHS that is not a private residence. Respite can only be provided in the home of another when the participant is using the self-determination option for service delivery. Each out-of-home respite service provider must be either a Medicaid-certified hospital or a licensed group home as defined in Michigan law, which includes AFC homes and Homes for the Aged. Properly licensed nursing facilities may be providers of out-of-home respite services.

Requirements	Each waiver agency must establish and follow written eligibility criteria for in-home respite that includes, at a minimum: ▪ Participants must require continual supervision to live in their own homes or the home of a primary caregiver, or require a substitute caregiver while their primary caregiver needs relief or is otherwise unavailable. ▪ Participants have difficulty performing or are unable to perform ADL without assistance. Respite services include: ▪ Attendant Care (participant is not bed-bound), such as companionship, supervision, and assistance with toileting, eating, and ambulation. ▪ Basic Care (participant may or may not be bed-bound), such as assistance with ADL, a routine exercise regimen, and self-medication. The direct service provider must obtain a copy of appropriate portions of the assessment conducted by the waiver agency before initiating service. The assessment information must include a recommendation made by the assessing RN describing the respite support services the participant needs. Each waiver agency or direct service provider must ensure the skills and training of the respite care worker assigned coincide with the condition and needs of the participant. With the assistance of the participant or participant's caregiver, the waiver agency or direct service provider must determine an emergency notification plan for each participant, pursuant to each visit. Each direct service provider must establish written procedures that govern the assistance given by staff to participants with self-medication. These procedures must be reviewed by a consulting pharmacist, physician, or RN and must include, at a minimum: ▪ The provider staff authorized to assist participants with taking their own prescription or over-the-counter medications and under what conditions such assistance may take place. This must include a review of the type of medication the participant takes and its impact upon the participant. ▪ Verification of prescription medications and their dosages. The participant must maintain all medications in their original, labeled containers. ▪ Instructions for entering medication information in participant files. ▪ A clear statement of the participant's and participant's family's responsibility regarding medications taken by the participant and the provision for informing the participant and the participant's family of the provider's procedures and responsibilities regarding assisted self-administration of medications. Each direct service provider must employ a professionally qualified supervisor that is available to staff during their shift while providing respite care. There is a 30-days-per-calendar-year limit on respite services provided outside the home. Respite services cannot be scheduled on a daily basis, except for longer-term stays at an out-of-home respite facility. Respite should be used on an intermittent basis to provide scheduled relief of informal caregivers. Members of a participant's family who are not the participant's regular caregiver may provide respite for the regular caregiver. However, waiver agencies must not authorize MI Choice funds to pay for services furnished to a participant by that

	person's spouse. Family members who provide respite services must meet the same standards as providers who are unrelated to the individual. The waiver agency must not authorize respite services to relieve a caregiver that receives waiver funds to provide another service to the waiver participant. This requirement may be waived if: ▪ The case record demonstrates the participant has a medical need for services and supports in excess of the authorized amount of MI Choice services (i.e., the participant has a medical need for 50 hours per week of services); and ▪ The case record demonstrates the paid caregiver furnishes unpaid services and supports to the participant (i.e., the caregiver is paid for 30 hours per week, but actually delivers 50 hours per week of services); and ▪ The paid caregiver is requesting respite for the services and supports not usually authorized through the MI Choice program (i.e., for all or part of the 20 hours of medically necessary, but unpaid services the caregiver regularly furnishes).
Limitations	MDHHS does not intend to furnish respite services on a continual basis. Respite services should be utilized for the sole purpose of providing temporary relief to an unpaid caregiver. When a caregiver is unable to furnish unpaid medically necessary services on a regular basis, waiver agencies should work with the participant and caregiver to develop a PCSP that includes other MI Choice services, as appropriate. The costs of room and board are not included. Waiver agencies cannot authorize respite services on a continual daily basis. Waiver agencies may authorize respite services on a daily basis for a short period, such as when informal supports are on vacation. Respite should be used on an intermittent basis to provide scheduled relief of informal caregivers. The waiver agency must not authorize waiver funds to pay for respite services provided by the participant's usual caregiver.

4.1.O. Specialized Medical Equipment and Supplies

Definition	Specialized Medical Equipment and Supplies includes devices, controls, or appliances which enable participants to increase their abilities to perform ADL, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support or to address physical conditions, along with ancillary supplies and equipment necessary to the proper functioning of such items. This includes durable and non-durable medical equipment and medical supplies not available under the State Plan that are necessary to address the participant's functional limitations. All items must be specified in the PCSP. This service excludes those items that are not of direct medical or remedial benefit to the participant. Durable and non-durable medical equipment and medical supplies not available under the State Plan that are necessary to address the participant's functional limitations may be covered by this service. Medical equipment and supplies furnished under the State Plan must be procured and reimbursed through that mechanism and not through MI Choice. All items must be specified in the participant's PCSP. All items must meet applicable standards of manufacture, design and installation. Coverage includes training the participant or caregiver(s) in the operation and

	maintenance of the equipment or the use of a supply when initially purchased. Waiver funds may also be used to cover the maintenance costs of equipment.
Requirements	Waiver agencies may obtain some items directly from a retail store that offers the item to the public (i.e., Wal-Mart, Meijer, Costco, etc.). When utilizing retail stores, the waiver agency must ensure the item purchased meets the service standards. The waiver agency may choose to open a business account with a retail store for such purchases. The waiver agency must maintain the original receipts and maintain accurate systems of accounting to verify the specific participant who received the purchased item. The waiver agency must document the medical or remedial benefit the equipment or supply provides to the participant in the participant's case record. Where feasible, the waiver agency or direct service provider must seek affirmation of the need for the item provided from the participant's physician. The waiver agency may provide liquid nutritional supplements as a specialized medical supply. The participant's physician or other health care professional must first order liquid nutritional supplements as described in the HDM service standards. When liquid nutrition supplements a participant's diet, the supports coordinator must ensure the physician or other health care professional renews the order for liquid nutritional supplements every six months.
Limitations	The waiver agency may not authorize MI Choice payment for prescription medications not found on the Medicaid prescription drug formulary. If a participant requires a medication not found on the formulary, the waiver agency, participant, or pharmacy must seek prior authorization of payment through the State Plan. Regardless of approval or denial of State Plan prior authorization, MI Choice funds must not pay for the medication. The waiver agency must not authorize MI Choice payment for herbal remedies or other over-the-counter medications for uses not authorized by the Food and Drug Administration (FDA).

4.1.P. SUPPORTS COORDINATION

Definition	Supports coordination is provided to ensure the provision of supports and services required to meet the participant's health and welfare needs in a home and community-based setting. Without these supports and services, the participant would otherwise require institutionalization. The supports coordination functions to be performed and the frequency of face-to-face and other contacts are specified in the PCSP. The frequency and scope of supports coordination contacts must take into consideration health and welfare needs of the participant. Supports coordination does not include the direct provision of other Medicaid services. Supports coordinators perform all functions described in the Supports Coordination Section of this Chapter.
Requirements	Each supports coordinator must have a valid Michigan license as a Registered Nurse (RN) or Social Worker (SW), and be trained and knowledgeable about the program requirements for MI Choice as well as other available community resources. Functions performed by a supports coordinator include: ▪ Ensure the participant meets the LOCD per MDHHS policy. ▪ Conduct the initial assessment and periodic reassessments.

	▪ Facilitate person-centered planning that is focused on the participant's preferences. Includes family and other allies as determined by the participant, identifies the participant's goals, preferences and needs, provides information about options, and engages the participant in monitoring and evaluating services and supports. ▪ Develop a PCSP, including revisions to the PCSP at the participant's initiation or as changes in the participant's circumstances may warrant. ▪ Communication with the participant is a requirement and must be incorporated into the person-centered service plan. ▪ Make referrals to and coordinate with providers of services and supports, including non-Medicaid services and informal supports. This may include providing assistance with access to entitlements or legal representation.
Limitations	Participant must need and agree to accept at least one additional MI Choice service every 30 days to qualify for the program. Supports coordinators must **not** also provide Transition Navigation under the Transition Services benefit.

4.1.Q. TRAINING

Definition	Training services consist of instruction provided to a MI Choice participant or caregiver(s) in either a one-to-one situation or a group basis to teach a variety of independent living skills, including the use of specialized or adaptive equipment or medically-related procedures required to maintain the participant in a community-based setting. The training needs must be identified in the comprehensive assessment or in a professional evaluation and included in the participant's person-centered service plan. Training is covered for areas such as ADL, adjustment to home or community living, adjustment to mobility impairment, adjustment to serious impairment, management of personal care needs, the development of skills to deal with service providers and attendants, and effective use of adaptive equipment. For participants self-directing services, training services may also include the training of independent supports brokers, developing and managing individual budgets, staff hiring and supervision, or other areas related to self-direction.
Requirements	Direct service providers must possess credentials required by Michigan laws or federal regulations, including: ▪ MCL 333.17801…333.17831 (physical therapist), ▪ MCL 333.18301…333.18311 (occupational therapist), ▪ MCL 333.18501…333.18518 (social worker), and/or ▪ MCL 333.17201…333.17242 (nursing) The waiver agency must identify the training needs in the comprehensive assessment or in a professional evaluation and include them in the PCSP. The waiver agency must provide a description of these needs to the direct service provider. The waiver agency must maintain verification of training provided to self-determined workers in the participant's case record.

4.2 State Plan Services

MI Choice services are designed to address the unique needs and circumstances of program participants. Some waiver services appear to be the same as services offered in the State Plan; however, they differ in terms of key elements, such as scope of coverage or provider qualifications. Inasmuch as waiver services are designed to meet the specific demands of participants, it is expected that a waiver service will be more appropriate for a participant than a similar State Plan service. Under no circumstances shall the participant receive both services. As a Prepaid Ambulatory Health Plan (PAHP), waiver agencies have authority to authorize payment only for MI Choice services for which they receive a capitated payment. Payments to the waiver agency for State Plan services may occur when the waiver agency is a properly enrolled provider for the specified service and conforms to conflict of interest protections.

4.3 Hospice or Palliative Care

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

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

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

4.4 Services in Licensed or Provider Controlled Settings

Licensing rules for residential setting providers reflect an attempt to make residing in these settings much like it would be in a home. Providers of licensed residential settings must meet the standards of providing a non-institutional setting licensed by the State of Michigan. For further details on what constitutes a home and community-based setting, refer to 42 CFR §441.530. Both licensed and non-licensed settings in which the provider has control over staffing arrangements and where MI Choice services are furnished must comply with the requirements of the Home and Community Based Services Chapter of this Manual.

4.5 Service Need Levels

Waiver agencies must classify each MI Choice participant into a service need level based upon the participant's immediacy of need for the provision of services and the availability of informal supports. Waiver agencies must establish and utilize written procedures consistent with the service need levels specified below to ensure each participant's needs are met in the event of an emergency. Waiver agencies must make direct service providers aware of the service need levels and the classification of

each participant served by that provider so that the service provider can target services to the highest priority participants in emergencies.

- Immediacy of need for the provision of services
  1. Immediate – the participant cannot be left alone
  2. Urgent – the participant can be left alone for a short time (less than 12 hours)
  3. Routine – the participant can be left alone for a day or two
- Availability of Informal Supports
  1. No informal supports are available for the participant
  2. Informal supports are available for the participant
  3. The participant resides in a supervised residential setting (SRS)

4.5.A. GRID OF SERVICE NEED LEVELS

Immediacy	Informal Supports	Service Need Level	Service Need Level Description
Immediate	None	1A	This means the participant cannot be left alone. If services are not delivered as planned, the backup plan needs to start immediately.
Immediate	Available	1B	This means the participant cannot be left alone. If services are not delivered as planned, family or friends need to be contacted immediately.
Immediate	SRS	1C	This means the participant cannot be left alone. Staff at the place of residence must be available as planned or follow established emergency procedures.
Urgent	None	2A	This means the participant can be left alone for a short time. If services are not delivered as planned, the backup plan needs to start within 12 hours.
Urgent	Available	2B	This means the participant can be left alone for a short time. If services are not delivered as planned, family or friends need to be contacted within 12 hours.
Urgent	SRS	2C	This means the participant can be left alone for a short time. Staff at the place of residence must check on the participant periodically each day. Follow established emergency procedures if no staff is present in the home.
Routine	None	3A	This means the participant can be left alone for a day or two. If services are not delivered as planned, the backup plan needs to start within a couple of days.
Routine	Available	3B	This means the participant can be left alone for a day or two. If services are not delivered as planned, family or friends need to be contacted within a couple of days.
Routine	SRS	N/A	There is not a 3C service need level because participants in supervised residential settings typically require 24-hour supervision and cannot be left alone for long periods.

4.6 SELF-DETERMINATION

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

- Recruiting staff
- Referring staff to an agency for hiring (co-employer)
- Selecting staff from worker registry
- Hiring staff (common law employer)
- Verifying staff qualifications
- Obtaining criminal history review of staff
- Specifying additional service or staff qualifications based on the participant's needs and preferences so long as such qualifications are consistent with the qualifications specified in the approved waiver application and the Minimum Operating Standards
- Specifying how services are to be provided and determining staff duties consistent with the service specifications in the approved waiver application and contract attachments
- Determining staff wages and benefits, subject to State limits (if any)
- Scheduling staff and the provision of services
- Orienting and instructing staff in duties
- Supervising staff
- Evaluating staff performance
- Verifying time worked by staff and approving timesheets
- Discharging staff (common law employer)
- Discharging staff from providing services (co-employer)
- Reallocating funds among services included in the participant's budget
- Identifying service providers and referring for provider enrollment
- Substituting service providers
- Reviewing and approving provider invoices for services rendered

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

Participants choosing the self-determination model for service delivery may also choose to utilize a supports broker to assist with developing the person-centered plan and securing other services (regardless of payer source) that may contribute to the participant's success in home and community-based living and improvements in their quality of life. Supports coordinators should inform all participants of this option and may assist the participant with selecting a supports broker, as needed.

The participant may, at any time, modify or terminate the self-determination option. The most effective method for making changes is the PCP process in which individuals chosen by the participant work with the participant and the supports coordinator to identify challenges and address problems that may interfere with the success of self-determination. The decision of a participant to terminate participation in self-determination does not alter the services and supports identified in the person-centered service plan, with the exception of the termination of the self-determination only services, Fiscal Intermediary, and Goods and Services. When the participant terminates self-determination, the waiver agency has an obligation to assume responsibility for ensuring the provision of all other services identified in the person-centered service plan through its provider network.

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

4.6.A. Self-Determined Providers

Participants choosing the self-determination option may directly manage service providers for the following home and community-based MI Choice waiver services: chore, community health worker, community living supports, environmental accessibility adaptations, fiscal intermediary, goods and services, community transportation, private duty nursing/respiratory care, respite services provided inside the participant's home, and respite services provided in the home of another.

4.6.A.1. Supervision of Direct-Care Workers

The MI Choice participant, or designated representative, acts as the employer and provides direct supervision of the chosen workers for self-determined services in the participant's PCSP. The participant, or designated representative, directly recruits, hires, and manages employees.

4.6.A.2. Use of a Fiscal Intermediary

MI Choice participants choosing the self-determination option must use an approved fiscal intermediary agency. The fiscal intermediary agency will help the individual manage and distribute funds contained in the participant's budget. The participant uses the funds in the budget to purchase waiver goods, supports, and services authorized in the participant's PCSP. Refer to the Fiscal Intermediary service standard for more information about this MI Choice service.

4.6.A.3. Reference and Criminal History Screening Checks

Each MI Choice participant, or fiscal intermediary chosen by the participant, must conduct reference checks and a criminal history screening through the Michigan State Police for each paid staff person who will be entering the participant's home. The MI Choice participant or fiscal intermediary must conduct the criminal history screening before authorizing the employee to furnish services in the participant's home. Waiver agencies must also check the Michigan Medicaid sanctioned provider list to determine if the provider is on the list; these providers must be excluded from providing any MI Choice services.

4.6.A.4. Provider Qualifications

Providers of self-determined services must minimally:

- Be 18 years old.
- Be able to communicate effectively both orally and in writing and follow instructions.
- Be trained in universal precautions and blood-borne pathogens. The waiver agency must maintain a copy of the employee's training record in the participant's case file.
- Providers of self-determined services cannot also be the participant's spouse, guardian, legally responsible person, or designated representative.

SECTION 5 – NURSING FACILITY TRANSITIONS

Serving individuals who require long-term supports and services in the least restrictive setting of their choice is a priority of MDHHS. The tenet of rebalancing the spectrum of long-term services and supports in Michigan was given impetus by the 1999 United States Supreme Court decision in Olmstead v. L. C.. Waiver agencies must enroll individuals who are transitioning or discharging from an institutional setting and who qualify for and choose the MI Choice program as slot capacity allows and according to waiting list prioritization. Waiver agencies will work with the Transition Services Transition Navigator or discharge planner to ensure MI Choice enrollment occurs on the date of transition or discharge for the individual to ensure the continuation of services for the individual.

SECTION 6 – SUPPORTS COORDINATION [CHANGE MADE 4/1/2026]

Supports coordination facilitates access to, and arrangement of, services and supports needed and chosen by MI Choice participants. These are detailed and documented in the person-centered service plan.

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

Waiver agency staff respects each participant's cultural background.

SCs must receive ongoing training and supervision, as appropriate.

The SCs ensure the participant's rights. This includes the right to participate actively in SC services including the development of the PCSP, the right to use a supports broker, the right to receive or refuse services, the right to choose providers, and the right to participate in a PCP process.

Every MI Choice participant signs a Freedom of Choice form to receive services from MI Choice. CHAMPS will generate this form for each participant once the completed LOCD is entered online. Waiver agencies follow the requirements defined in the Nursing Facility Level of Care Determination Chapter of this Manual. Participants must be informed of the following:

- Services available in MI Choice, PACE, MI Health Link/MI Coordinated Health, **(revised per bulletin MMP 25-47)** and nursing facilities. Participants or their legal representative must sign the Freedom of Choice form to indicate their preference for MI Choice. Waiver agencies maintain properly completed, signed, and dated forms in the participant's case record. Waiver agencies must make attempts to get the participant or legal representative to sign the Freedom of Choice form, but a refusal or inability to sign the form is not a reason to deny MI Choice services. If the participant or legal representative refuses to or is unable to sign the form, and the waiver agency has attempted to obtain the signature with documentation of attempts in progress notes, the waiver agency should document this on the Freedom of Choice form. The form should then be maintained in the participant's file. (Refer to additional Freedom of Choice requirements within this chapter.)
- Services available through the State Plan which may meet their needs. Examples include the Home Help program available through the MDHHS Field Office. Persons who qualify for the Home Help program and for whom this program will fully meet their services and support needs do not qualify for the MI Choice program because they do not have the need for a waiver service.

SCs instruct participants regarding how to contact SCs when needed for service and supports changes.

SCs provide all of the following functions: social emotional support, advocacy, assessment, person-centered service planning and development, service access, follow-up and monitoring, and reassessment.

6.1 Social Emotional Support

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

6.2 Advocacy

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

6.3 Assessment

The MI Choice program has established the Resident Assessment Instrument – Home Care (iHC) as the approved assessment instrument for assessing the functional status of participants. The iHC Assessment System, consisting of the iHC and Clinical Assessment Protocols (CAPs), is the basis for the MI Choice assessment. SCs perform a comprehensive evaluation including assessment of the individual's unique preferences; physical, social, and emotional functioning; medication; physical environment; natural supports; and financial status. The SC must fully engage the participant in the interview to the extent of the participant's abilities and tolerance. The initial assessment must be conducted in person.

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

SCs also conduct the LOCD tool to determine if the individual meets functional eligibility.

Qualified SCs perform the initial MI Choice assessment function as a team. Qualified staff includes a RN or SW, both with valid Michigan licenses to practice their profession.

The MI Choice Intake Guidelines, LOCD, and iHC are not interchangeable tools.

6.4 Person Centered Planning and Service Plan Development

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

6.4.A. Person-Centered Planning

Person-centered planning (PCP) is a process for planning and supporting a participant receiving services that builds on the participant's desire to engage in lawful activities that promote community life and that honor the participant's preferences, choices, and abilities. The PCP process involves families, friends, and professionals as the participant desires or requires. Waiver agencies and direct service providers must utilize a PCP

process, informing the participant of service options in ways that are meaningful to the participant. This includes assessing the needs and desires of the participant, developing the person-centered service plan, and continuously updating and revising those plans as needs and desires change. The participant and their chosen representative(s) must be provided with written information from the waiver agency detailing the right to participate in the PCP process. Waiver agencies and direct service providers implement PCP in accordance with the MDHHS Person-Centered Planning Guideline document that may be found in the Directory Appendix of this Manual.

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

SCs follow the principles of PCP, including providing opportunities for participants to express goals, desires, and expectations and supporting the involvement of allies to participate in planning activities.

SCs identify and discuss all potential supports and service options and emphasize participant choices and preferences.

The participant directs the PCP process. The process:

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

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

6.4.A.1. Participant Management of Risk

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

CMS and MDHHS require waiver agencies to assist MI Choice participants in managing the risks associated with choosing home and community-based service programs over institutionalization. Risk management is part of assuring the health and welfare of MI Choice participants. "The identification of potential risks to waiver participants and the development of strategies to mitigate such risks are integral to enabling participants to live as they choose in the community while assuring their health and welfare. Critical risks should be addressed during the PCSP development process by incorporating strategies into the plan to mitigate whatever risks may be present" (CMS Instructions, Technical Guide and Review Criteria, Version 3.5 HCBS Waiver Application).

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

Waiver agencies may require participants to acknowledge when their choices pose risks for their health and welfare. MDHHS does not obligate the waiver agency to authorize services believed to be harmful to the participant. The SCs initiate negotiations of such issues in the PCP process. The SCs educate the participant to ensure the participant makes informed choices concerning their risks. The SCs inform service providers of a participant's risk status when ordering services in the traditional MI Choice program. The participant or, if preferred, the SC informs service providers of the participant's risk status when the participant chooses the self-determination. MDHHS requires agency providers, including waiver agencies, to have a contingency plan for emergencies that pose a serious threat to participant health and welfare (i.e., inclement weather, natural disasters, and unavailable caregiver.)

Each PCSP describes backup plans to implement when selected service providers are unable to furnish services as planned. This may involve developing lists of alternative qualified providers, using a provider agency or informal supports, or contacting the SC when planned services are unavailable. Additionally, the waiver agency develops an emergency plan with each participant that clearly describes a preferred course of action

when the participant has an emergency. SCs discuss and incorporate contingency plans into the individual PCSP during the PCP process.

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

Clinical Assessment Protocols (CAPs) and Triggers

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

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

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

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

Service Need Levels Based on Identified Risks

SCs fully discuss strategies to mitigate risk with the participant and their allies, family, and relevant others during PCP. The SCs inform the participant of risks and educate the participant about consequences of chosen risks, as necessary. SCs document the participant's informed choice in the case record. SCs document participant-approved risk strategies and write them into the PCSP.

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

SCs identify the service need level of each participant according to the Special Need Levels subsection of this chapter. SCs inform service providers of a participant's service need level when ordering services.

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

- The use of alternative methods to avoid the use of restraints and seclusion;
- Methods used by SCs to detect the use of restraints;
- The protocols that SCs, service providers, and allies must follow when the use of restraints or seclusion are identified;
- The practices that must be employed to ensure the health and welfare of individuals; and
- Documentation that is required concerning the use of restraints or seclusion.

Contingency Planning

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

The development of contingency plans is one way to address some of the risks encountered by MI Choice participants. MDHHS identifies both emergency plans and backup plans as contingency plans for MI Choice participants. Contingency plans may be a single document that incorporates both the emergency plan and the backup plan. Waiver agencies assist all participants in the development of an effective contingency plan crafted to meet the unique needs and circumstances of each MI Choice participant. Waiver agencies must use the service need levels as identified and required in this chapter.

Waiver agencies retain a copy of each participant’s contingency plan in the participant record and provide additional copies to the participant, service providers, and other allies included in the plan, as preferred by the participant. The contingency plan is updated as

needed, and the waiver agency sends the participant, service providers, and other allies a copy of the contingency plan after each update.

Emergency Plans

- An emergency is a situation or event that places participant health or life in danger and requires immediate action or medical attention to prevent physical harm or hospitalization. Emergencies include natural disasters (tornados, floods, drought, heat waves, blizzards, etc.), unnatural disasters (fires, bomb threats, terrorism, etc.), and sudden onset of medical crises.
- The waiver agency encourages participants to use a PERS or dial "911" during an emergency.
- Participants whose life depends upon equipment that requires electricity have an emergency plan that addresses what to do during a power outage, or clearly states the participant's preference not to include such measures.
- Participants who need assistance to ambulate have an emergency plan that includes the notification of someone who will assist them in evacuating their residence if necessary, or clearly state the participant's preference not to include such measures.
- MDHHS urges all participants to have escape routes defined for various disasters.
- MDHHS urges all waiver agencies to be involved with law enforcement officials and other disaster preparedness agencies at the local level to help these agencies identify and assist MI Choice participants during emergencies.

Backup Plans

- Backup plans provide for alternative arrangements for the delivery of services that are critical to participant well-being in the event that the provider responsible for furnishing the services fails or is unable to deliver them (CMS Instructions, Technical Guide, and Review Criteria, Version 3.5 HCBS Waiver Application). Backup plans are employed when scheduled providers do not show up as expected.
- Each contracted service provider shall have established policies and procedures that reasonably ensure the delivery of services to participants in the event that the regularly scheduled provider is unable to furnish the service.
- The waiver agency notifies providers of the participant's service need level. This information shall also be included in the backup plan for each participant.
- Backup plans should minimally include contact information for all providers furnishing critical services to the participant. A critical service is a service the participant must receive as planned and as specified in the service need level of the participant.
- Backup plans should include methods for the participant and provider agency to contact the SC if a provider does not deliver a service as planned.
- Backup plans should include provisions for furnishing services when an unpaid caregiver is unable to provide a service that is critical to the participant and usually provided by that ally.

- Backup plans should clearly state the participant's preferences for receiving services and supports if the regularly scheduled provider cannot furnish the services and supports. Waiver agencies develop policies and procedures to track the following:
  - When backup plans are activated;
  - When the backup service provider furnished services; and
  - When service is not provided following activation of backup plans.

6.4.B. Person-Centered Service Plan

The participant's PCSP is an individualized, comprehensive document developed by the participant, their chosen representative(s), and the supports coordinator prior to the provision of services. Using a person-centered process, waiver agencies must establish a written PCSP for each participant that identifies the participant's strengths, weaknesses, needs, goals, expected outcomes, and planned interventions. This document includes all services provided to, or needed by, the participant regardless of funding source. An initial PCSP must be completed within 10 days of the program enrollment date. The full PCSP is developed when the participant is not in crisis and may build upon an interim care plan, but should be completed within 90 days of MI Choice enrollment. The participant must approve all services and interventions before implementation and the waiver agency must document participant approval. MI Choice services must be stipulated in the PCP process and the participant assessment. Requirements for the PCSP are defined in the Home and Community Based Services Chapter of this Manual.

Using a person-centered planning process, each waiver agency must establish a written person-centered service plan (PCSP) for each participant based upon the assessment of needs, goals, and preferences. The waiver agency and participant must develop the PCSP before providing services. The participant must approve of all services in the PCSP. The waiver agency must document participant approval on the PCSP.

The PCSP must contain, at a minimum:

- The individual chose the setting in which they reside
- The services and supports that are important to the individual to meet the needs identified during the individual's assessment
- The individual's strengths and preferences
- The clinical and support needs identified by a functional assessment
- The amount of service authorized
- The frequency and duration of each service, and the individual's preference for receiving those services and supports
- Units of each service per visit and per week
- Cost per unit
- Total cost of service plan
- Start and stop dates for each service

- The type of provider to furnish each service
- Participant-focused goals and outcomes
- For participants receiving home-delivered meals, notations regarding the number of meals served per day, the days of service, and special diet orders or requests
- Risk factors and measures identified to mitigate them
- Individuals responsible for monitoring the plan
- The informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation

Informal Supports are unpaid supports that choose to volunteer their time to assist participants in lieu of MI Choice services and supports. If informal supports are involved as providers of services, they are not required to sign the PCSP, but must be notified about the duties they are expected to perform for the participant. The participant or legal representative takes responsibility for ensuring these duties are completed and must sign the PCSP indicating they are accepting the responsibility. If the participant or legal representative has not had the discussion with the informal support(s), and prefers the supports coordinator to follow up with the informal support(s), the supports coordinator must do so and document this in the PCSP. If the informal supports are unable to carry out their responsibilities, or the supports coordinator notices during a home visit that the duties have not been performed, the supports coordinator will notify the informal support(s) of the duty to be performed. If the informal support cannot be reached, or refuses to perform the duty, the supports coordinator will discuss other arrangements (formal or informal) with the participant and legal representative. Documentation in the PCSP must be done in a place that is carried from one PCSP update to the next.

The PCSP reflects the SC's authorization to implement participant-approved services. The SC updates the PCSP as frequently as necessary or preferred, but at least every 90 days after the initial assessment, then 180 days after that or as desired by the participant and documented in the PCSP.

6.5 Service Access

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

6.6 Follow-Up and Monitoring

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

Waiver agencies must maintain local policy and procedures, assuring that participants have a continuous opportunity to provide feedback about services, supports, interventions, and treatments.

SCs must contact participants as determined by the participant in their PCSP (usually about every 30 days) to monitor the participant's health and welfare, the provision of services (including verification of the delivery of one-time services), and the participant's satisfaction with the current PCSP. SCs and participants can adjust services at this time to serve the participant better. SCs should contact the participant no less frequently than every 90 days, unless the participant chooses otherwise.

SCs must contact newly enrolled participants within 14 days of the agreed upon service start date to verify the providers deliver services in the manner arranged and to the satisfaction of the participant. SCs may contact the service provider in addition to contacting the participant to verify the provision of services and any issues identified by the provider. This requirement does not apply to changed services or participants who are re-enrolling in the MI Choice program after a brief disenrollment period.

For participants who enroll in MI Choice upon discharge from a nursing facility or hospital, the supports coordinator must ensure the participant's necessary services or supplies are in place prior to discharge. After the participant's discharge, the supports coordinator must contact the participant within 24 hours of discharge to ensure immediate needs are being met. Within seven (7) days of the discharge, the supports coordinator must conduct an in-person meeting (home visit) with the participant to ensure the previous assessment is still valid, and update as necessary. A full reassessment may be done at that time if the situation warrants it.

An in-person meeting (home visit) must be completed within seven (7) days of a participant moving/transferring from one residence to another (not nursing facility or hospital) to ensure that the participant's needs are being met and to update any assessments as necessary.

SCs must record changes in services negotiated during follow-up and monitoring on behalf of participants in the participant's PCSP.

SCs must provide oral or written feedback to providers regarding services furnished according to the PCSP when the SC receives complaints from participants.

When SCs attempt to arrange a service that cannot start within 30 days, they must contact the provider agency every 30 days until a provider can implement the service. When a network provider is not available, the waiver agency must use an out-of-network provider to furnish approved services until an in-network provider is secured.

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

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

Follow-up and monitoring must be conducted by a SC or someone who otherwise meets the qualifications to be a SC (i.e., is a licensed nurse or social worker) and is acting as a SC in the absence of the participant's assigned SC. Examples of acting in the absence of the participant's assigned SC include situations where the assigned SC is on vacation, sick leave, medical leave, or has permanently left the waiver agency and another SC has not yet been assigned.

6.7 Reassessment

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

SCs must provide a face-to-face reassessment to program participants within 90 days of the initial assessment or sooner when there are significant changes in the participant's health or functional status, or significant changes in the participant's network of allies (i.e., death of a primary caregiver). Reassessments may be completed virtually (audiovisual) only if the participant chooses that method.

SCs must provide a subsequent face-to-face annual reassessment to participants or sooner when there are significant changes in the participant's health or functional status, or significant changes in the participant's network of allies (i.e., death of a primary caregiver).

The reassessment is comprehensive and includes review of the same items evaluated during the previous assessment.

The SC may only copy and paste information that has not changed from a previous assessment to the new assessment when the information is still relevant.

The case record must reflect documentation that the participant continually meets the LOCD. The record must indicate the appropriate door through which the participant meets the LOCD criteria based upon the current assessment. If the SC does not complete a paper copy of the LOCD determination tool, the corresponding iHC assessment data MUST support the door through which the SC indicates the participant meets LOCD criteria.

The SC reviews reassessment findings with the participant. The SC and the participant update the PCSP, if necessary, based on mutually agreed upon service changes. The participant approves each service change. The SC sends appropriate notice to the participant and, when necessary, obtains a clearly written, signed statement from the participant that acknowledges the agreed upon change before service changes can be put into place.

When one SC completes an assessment, that SC should consult with an SC of the other discipline to ensure all relevant issues have been updated and properly addressed.

When one SC completes an assessment and identifies participant issues that would be better addressed by the other discipline, OR when the other discipline reviewed the assessment completed by a single SC and identified additional issues, a SC from the other discipline shall do the following in collaboration with the other SC and discuss with a supervisor:

- Perform follow up with the first SC to ensure the record properly addresses the issues, AND
- When indicated by professional judgment as the best course of action, contact the participant to ensure the issues are properly captured within the record and update the PCSP as needed, OR
- When indicated by professional judgment as the best course of action, conduct another in-person reassessment within the next seven days to verify the first SC's findings and ensure the record properly reflects and addresses all issues.

The SC includes reassessments in the participant case record.

Participants may refuse reassessment. SCs document this refusal in the case record. However, to maintain program eligibility, the waiver agency must assess all program participants on an annual basis.

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

The SC also documents that the participant continues to meet the nursing facility level of care within the case record, specifying the appropriate "door" through which the participant meets level of care criteria. If a supports coordinator suspects the participant no longer meets the nursing facility level of care, the supports coordinator must conduct a face-to-face LOCD and input the data into the LOCD application in CHAMPS. When CHAMPS confirms the individual no longer meets LOCD criteria, the supports coordinator initiates program discharge procedures and provides the participant with notice and information on appeal rights. A refusal which prevents a timely redetermination is cause for termination from the program.

SECTION 7 – ADMINISTRATION

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

7.1 WAIVER AGENCIES AS PREPAID AMBULATORY HEALTH PLANS

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

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

Waiver agencies are responsible for securing qualified service providers to deliver services. Eligible provider applicants include public, private non-profit or for-profit organizations that provide services meeting established service standards, certifications or licensure requirements. Participants may only use providers in the waiver agency's provider network, unless no willing provider is available within the waiver agency's network. Waiver agencies must ensure MI Choice services identified in the person-centered service plan are furnished according to the plan, which may include utilizing providers outside of the provider network, as specified in 42 CFR §438.206, until such time as a network provider is able to furnish the service.

7.2 WAITING LIST REPORTING

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

7.3 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

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

7.4 TRANSFERRING MI CHOICE PARTICIPANTS TO ANOTHER WAIVER AGENCY

MDHHS ensures participants have a choice of a waiver agency, as available, to coordinate MI Choice services. A participant may choose to transfer enrollment from one waiver agency to another, as available within the region where they live, or a participant may move to another region of the State.

Waiver agencies are responsible for managing transfers of participants to other agencies or accepting transfers from another agency and are required to:

- Ensure that participants are transferred from one agency to another, preserving continuity of care and the integrity of the participant's preferences and PCSP.
- The new waiver agency must perform an initial assessment. This may include an LOCD if an active LOCD is not available in CHAMPS or the participant has significant changes. The new waiver agency must either enter an LOCD in CHAMPS or adopt the current LOCD as specified in LOCD policy for the transferred participant within 14 calendar days after the date of the participant's enrollment in the new waiver agency's program, or otherwise according to MDHHS LOCD policy.
- The new waiver agency for each transferred participant must not reimburse providers for delivered MI Choice services authorized by a previous waiver agency. The new waiver agency reviews PCSP activity and authorizes a new PCSP with the participant.

The waiver agency the participant transferred from is responsible for closing the participant enrollment at that agency so that the new agency can enroll the participant in its MI Choice program. The waiver agency the participant transferred from is responsible for entering disenrollment information in CHAMPS so that the waiver agency the participant is transferring to may enter enrollment information in CHAMPS.

7.5 Release of Information and Consent

The participant shall authorize the use or disclosure of PHI under HIPAA by signing a Release of Information and Consent Form (ROI). The ROI shall include the following information:

- Permission to use or disclose PHI for purposes beyond treatment, payment, or health care operations.
- A description of the PHI to be disclosed.
- The purpose for the disclosure.
- The intended recipient(s).
- The participant's right to withdraw consent of release at any time.
- The date the authorization expires, not to exceed one year from the date of participant signature.
- Participant or legal representative signature and date. A relative or other representative may only sign the release when the participant is determined legally incompetent or is physically unable. The case record must clearly document why participants cannot sign the ROI themselves.
- The signature and date of SC completing the form.

7.6 Case Record Requirements

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

agencies that maintain case information in electronic format to maintain hard copy case records. However, the waiver agency must make electronic case records available to MDHHS or other reviewers when conducting audits and other authorized reviews.

7.6.A. Case Records

Each enrolled MI Choice participant has an individual case record. All forms required in the case record must be properly completed according to policy or form instructions. The case record shall include, but is not limited to, the following required information:

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

Additional requirements for case records include:

- Waiver agencies maintain MI Choice case records in a manner that conforms to good professional practice, permits effective professional review and audit, and facilitates an adequate system for follow up.
- Writers enter hard copy case record information in ink.
- Electronic Health Records (EHR) or Health Information Systems (HIS) (such as MICIS, COMPASS, or other systems for collecting case record documentation electronically) must have a method to lock records upon submission of data into the EHR that conforms to industry standards. The system must track all changes made to all information entered into the system including the date, time, and user making the change.
- Waiver agency staff either signs or initials each entry in the case record. When using initials, the waiver agency maintains a signature log sheet with employees' names and initials. EHR shall record the user information for data entered in the case record.
- Writers make corrections to case record entries by drawing a line through the incorrect information and entering corrected information above, below or adjacent to the previous entry. Whether written or electronic, under no circumstances shall information included in the case record be permanently erased. Electronic records shall include a method to correct information without erasing that information, such as using a strikethrough font. Additionally, electronic records shall include a backup system to retrieve any lost data due to system errors.

- Writers identify late entries. MDHHS allows waiver agencies to make late entries in the case record as long as the writer notes that they made the entry sometime after the contact occurred. Writers may not enter previously omitted information as a late entry more than seven (7) days after the contact occurred (see how to amend a record below).
- Writers may amend the record at any time by identifying an entry as a record amendment and describing previously omitted information. This type of entry should describe why the entry is being made (i.e., after peer or supervisory review) and who is making the amendment.
- Writers may add entries to the record to correct earlier entries of electronic records that contained erroneous or inaccurate information.
- Only the person that entered the original data into the EHR may edit that data. If this is not possible, other users may include a corrective note in the EHR that explains the error in the original data but may not change the original data.
- The system must date and time stamp all EHR entries and include the username under which the entry was made. The agency must keep a list of all usernames and the identification of the individual associated with that username.
- Waiver agencies maintain a copy of participant enrollment files to support capitated payments made through CHAMPS.
- Waiver agencies maintain a record of payments made to providers.
- Waiver agencies monitor contractors and subcontractor activity and maintain records and reports of the reviews and findings.
- Waiver agencies maintain necessary records that disclose fully the extent of service provided to each participant for a period of ten (10) years for the purpose of subsequent audit.

SECTION 8 – FINANCING AND REIMBURSEMENT

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

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

8.1 STATE REIMBURSEMENT TO WAIVER AGENCIES

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

Capitation payments will be processed through files generated in CHAMPS on a monthly basis. This file contains an electronic listing of individuals who are enrolled in the MI Choice program with each waiver agency. The Medicaid Management Information System (MMIS) then performs quality checks, including:

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

Payment to waiver agencies will occur through an electronic funds transfer on the fourth Wednesday of the month. This payment will be available to waiver agencies on the Thursday following the fourth Wednesday of the month.

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

8.2 ENCOUNTER DATA REPORTING

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

8.3 Administrative Expense and Other Financial Reporting

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

8.4 Financial Audit Requirements

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

Waiver agencies that expend $750,000 or more in federal awards during the agency's fiscal year must submit to MDHHS a Single Audit that is consistent with the Single Audit Act Amendments of 1996 and Office of Management and Budget (OMB) Title 2 CFR Subpart F and include all components described in 2 CFR §200.512(c).

Waiver agencies exempt from the Single Audit requirements that receive $750,000 or more in total funding from MDHHS in state and federal grant funding must submit to MDHHS a Financial Statement Audit prepared in accordance with Generally Accepted Auditing Standards (GAAS). Waiver agencies exempt from the Single Audit requirements that receive less than $750,000 of total MDHHS grant funding must submit to MDHHS a Financial Statement Audit prepared in accordance with GAAS if the audit includes disclosures that negatively impact MDHHS-funded programs including, but not limited to, fraud, financial statement misstatements, and violations of contract and grant provisions.

Waiver agencies exempt from both the Single Audit and Financial Statement Audit requirements (sections a and b) must submit an Audit Status Notification Letter that certifies these exemptions. The template for the Audit Status Notification Letter and further instructions are available on the MDHHS website. (Refer to MI Choice Waiver Resources in the Directory Appendix for additional information.)

The required audit and any other required submissions (i.e., Corrective Action Plan and management letter with a response, or Audit Status Notification Letter) must be submitted within nine months following the end of the contractor's fiscal year to MDHHS.

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

SECTION 9 – PROVIDERS

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

9.1 ENROLLMENT OF SERVICE PROVIDERS

Waiver agencies must use written contracts meeting the requirements of 42 CFR §434.6 to purchase services. Entities or individuals under subcontract with the waiver agencies must meet provider standards defined in this Chapter and the MI Choice Contract. Only providers meeting the requisite waiver requirements are permitted to participate in the waiver program.

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

9.2 FAMILY MEMBERS AS SERVICE PROVIDERS

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

9.3 REIMBURSEMENT RATES FOR PROVIDERS

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

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

9.4 CRIMINAL HISTORY REVIEWS

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

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

Waiver agencies must also check the MDHHS Sanctioned Providers List and must not contract with any providers on this list for the duration of the sanction period until approved by MDHHS to resume providing services. The MDHHS Sanctioned Provider List is located on the MDHHS website. (Refer to the Directory Appendix for website information.)

9.5 Use of Restraints, Seclusion or Restrictive Interventions

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

An exception to restraints or restrictive intervention is bed rails or bed canes. If bed rails or bed canes are used, this must be based upon assessed need for the participant and documented in the person-centered service plan. If the participant resides in a provider-controlled setting, there must be an order from a licensed medical professional, and this must be kept on file in the participant's case record at the waiver agency. As per requirements in federal law and the Home and Community-Based Services Chapter in this Manual, the use of bed rails or bed canes must be reviewed on an annual basis to ensure they are still required. If no longer required, the bed rail or bed cane must be removed.

9.6 Contributions

Neither the waiver agency nor any service provider under contract with the waiver agency may require monetary donations from participants of the MI Choice waiver program as a condition of participation in the MI Choice waiver.

The waiver agency and each direct service provider must accept MI Choice payments for services as payment in full for such services. Consistent with the Code of Federal Regulations, Chapter 42, Section 438.60 (42 CFR §438.60), service providers must not seek nor receive payment other than payment from the waiver agency for services covered under the Contract between MDHHS and the waiver agency, except when these payments are specifically required to be made by the State in Title XIX of the Social Security Act, in 42 CFR chapter IV, or when MDHHS makes direct payments to service providers for graduate medical education costs approved under the State Plan.

No paid or volunteer staff person of a direct service provider may solicit contributions from program participants, offer for sale any type of merchandise or service, or seek to encourage the acceptance of any particular belief or philosophy by any program participant.

9.7 Confidentiality

Each waiver agency and direct service provider must have procedures to protect the confidentiality of information about participants or persons seeking services collected in the conduct of its responsibilities. The procedures must ensure that no information about a participant or person seeking services, or

obtained from a participant or person seeking services by a service provider, is disclosed in a form that identifies the person without the informed consent of that person or of their legal representative. However, disclosure may be allowed by court order, or for program monitoring by authorized federal, state, or local agencies (which are also bound to protect the confidentiality of the client information), so long as access is in conformity with the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996. Waiver agencies and direct service providers must maintain all client information in controlled access files. This requirement applies to all protected information whether written, electronic, or oral.

9.8 Compliance with Home and Community Based Services Settings Requirements

Each waiver agency and direct service provider must comply with the Federal Home and Community Based Services Settings Requirements as specified in 42 CFR §441.301(c)(4) as well as in the Home and Community-Based Services Chapter of this Manual. Direct service providers with subcontracts secured prior to March 17, 2019 must be fully compliant with this regulation by March 17, 2019, unless they are included in the heightened scrutiny process. All direct service providers added to the waiver agency's provider network after March 17, 2019 must be compliant with this ruling before the direct service provider may furnish services to a waiver participant.

MDHHS will use the following process to ensure compliance to this requirement:

- Each waiver agency will assess all applicable providers annually using a MDHHS-approved survey. In some situations described below within this section, the results of the surveys will be submitted electronically to MDHHS for a determination of compliance to the requirements.
- MDHHS will notify both the provider and the MI Choice waiver agency regarding the provider's compliance based upon the completed survey tool that was submitted to MDHHS.
- For providers who are non-compliant, the provider will have one to two weeks to correct all issues that cause the non-compliance.
- Once the issues are corrected, the provider will notify the waiver agency and schedule another on-site survey.
- The waiver agency will have one to two weeks to complete another on-site survey and submit the survey to MDHHS for review within 10 days of the visit.
- If a provider does not contact the waiver agency within one to two weeks, the waiver agency will contact the provider to determine progress on the corrective action and schedule another on-site visit accordingly.
- If the provider has not satisfactorily resolved the compliance issues, the waiver agency will suspend the provider from receiving new MI Choice participants until such time as the provider comes into compliance.
- Some providers may require Heightened Scrutiny to determine compliance. These providers will follow the Heightened Scrutiny Process defined by MDHHS to ensure compliance and to continue participation with the MI Choice program.
- Regardless of the original notification date, all providers in all MI Choice provider networks will be compliant with the ruling no later than March 17, 2019, or the date approved in the State Transition Plan, whichever is sooner.

- Waiver agencies must have completed person-centered transition plans with individuals served by non-compliant providers before March 17, 2019.
- By March 17, 2019, no MI Choice participants will be served by non-compliant providers, and all non-compliant providers will be removed from the MI Choice provider network.
- For MI Choice participants residing in a provider-owned and controlled setting, the waiver agency must keep a copy of the lease agreement and resident care agreement on file.

9.9 Notifying Participant of Rights

Each waiver agency or direct provider of home-based services must notify each participant, in writing, at the initiation of service of their right to comment about service provision or appeal the denial, reduction, suspension, or termination of services. Such notice must also advise the participant that they may file complaints of discrimination with the respective waiver agency, the Department of Health and Human Services Office of Civil Rights, or the Michigan Department of Civil Rights. The MI Choice Participant Handbook meets this requirement.

9.10 Selection of a Provider to Furnish Services

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

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

9.11 Additional General Requirements for Providers [Change Made 7/1/2026]

- Waiver agencies have policies and procedures to identify and prevent problems with access to MI Choice services. Access issues include, but are not limited to, problems with provider availability and adherence to the participant approved PCSP.
- Waiver agencies and service providers enter into contractual agreements that include required assurances for nondiscrimination, minimum provider service standards, and contract requirements included in 42 CFR §434, 42 CFR §438, and the MDHHS Health Services **(revised 7/1/2026)** provider enrollment agreement.
- The waiver agency maintains written minimum service standards for MI Choice services that fulfill licensure and certification requirements mandated by CMS and that comply with the CMS-

approved MI Choice waiver application and the MDHHS Minimum Operating Standards for MI Choice Services.

- The waiver agency has written procedures to secure competitive, per unit rate agreements from qualified service providers.
- The provider enrollment process includes a description of the frequency and method of verifying and monitoring staff qualifications and how the waiver agency documents this verification. MDHHS defines a willing provider as a provider who agrees to accept Medicaid payment as payment in full for rendering a service, abides by all other Medicaid provider requirements, including executing provider agreements, and adheres to the required service standards.
- Waiver agencies must allow Medicaid beneficiaries to select from any qualified provider within the waiver agency's provider network.
- Waiver agencies must provide MI Choice services to any participant who needs the service. Waiver agencies may not limit the number of MI Choice participants who receive a service or deny a needed MI Choice service for any reason (e.g., lack of funds). Waiver agencies must make MI Choice services available on a comparable basis to all MI Choice participants based on need.
- The 21st Century Cures Act (the Cures Act), enacted by the U.S. Congress in December 2016, added Section 1903(l) to the Social Security Act to require all states to use electronic visit verification (EVV) for personal care services (PCS) and home health care services (HHCS) provided under a Medicaid State Plan of the Social Security Act or under a waiver of the State Plan. PCS provided through MI Choice must meet EVV requirements. Refer to the Electronic Visit Verification chapter of this Manual for more information.

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

9.12 Home-Based Services Providers

MI Choice waiver home-based services include community living supports, respite services provided in the home, chore services, personal emergency response systems, private duty nursing/respiratory care, nursing services, counseling, home delivered meals, training services, and community health workers.

9.12.A. Participant Assessments

Direct providers of home-based services must avoid duplicating assessments of individual participants to the maximum extent possible. Home-based service providers must accept assessments conducted by waiver agencies and initiate home-based services without having to conduct a separate assessment unless there is a legitimate reason to conduct the separate assessment. Waiver agencies must make every attempt to supply direct providers of home-based services with enough information about each participant served by that organization to provide needed services properly.

9.12.B. Supervision of Direct-Care Workers

Home-based service providers must always have a supervisor available to direct care workers while the worker is furnishing services to MI Choice participants. The provider

may offer supervisor availability by telephone. Home-based service providers must conduct in-home supervision of their staff at least twice each fiscal year. A qualified professional must conduct the supervisory visit.

9.12.C. Participant Records

Each direct provider of home-based services must maintain comprehensive and complete participant records that contain, at a minimum:

- Details of the request to provide services.
- A copy of the waiver agency's evaluation of the participant's need (this may be appropriate portions of the MI Choice assessment or reassessment).
- Service authorizations or work orders.
- Providers with multiple sources of funding must specifically identify waiver participants; records must contain a listing of all dates of service for each participant and the number of units provided during each visit.
- Notes in response to participant, family, and agency contacts (not required for home-delivered meal programs).
- A record of release of any personal information about the participant and a copy of a signed release of information form.

Direct providers of home-based services must keep all participant records (written, electronic, or other) confidential in controlled access files for a minimum of 10 years.

9.12.D. In-Service Training

Staff of waiver agencies and direct providers of home-based services must receive in-service training at least twice each fiscal year. Waiver agencies and providers must design the training so that it increases staff knowledge and understanding of the program and its participants, and improves staff skills at tasks performed in the provision of services. Waiver agencies and direct providers of home-based services must maintain comprehensive records identifying dates of training and topics covered in an agency training log or in each employee's personnel file. The employer must develop an individualized in-service training plan for each employee when performance evaluations indicate a need.

9.12.E. Additional Conditions and Qualifications

Each waiver agency and direct provider of home-based services will assure MDHHS that employees or volunteers who enter and work within participant homes abide by the following additional conditions and qualifications:

- Service providers must have procedures in place for obtaining participant signatures on the time sheets (or similar document) of direct care workers to verify the direct service worker provided the work ordered by the waiver agency. Electronic Visit Verification (EVV) systems may take the place of this requirement as long as the verification is

available to the waiver agency. If providers are utilizing EVV systems, paper time sheets are not needed.

- Direct service workers are prohibited from smoking in participant's homes.
- Direct service workers must demonstrate the ability to communicate adequately and appropriately, both orally and in writing, with their employers and the MI Choice participants they serve. This includes the ability to follow product instructions properly in carrying out direct service responsibilities (i.e., read grocery lists, identify items on grocery lists, and safely use cleaning and cooking products).
- Direct service workers must not use their cell phones for personal use while in a participant's home. Exceptions may be made in cases of emergency. Direct service workers should engage with the participants while furnishing the services specified on the person-centered service plan.
- Direct service workers must not threaten or coerce participants in any way. Failure to meet this standard is grounds for immediate discharge.
- Waiver agencies will inform service contractors and direct service workers promptly of new service standards or any changes to current services standards.

9.13 Insurance Coverage

Each waiver agency and direct service provider must have sufficient insurance to indemnify loss of federal, state, and local resources due to casualty or fraud. Insurance coverage sufficient to reimburse MDHHS or the waiver agency for the fair market value of the asset at the time of loss must cover all buildings, equipment, supplies, and other property purchased in whole or in part with funds awarded by MDHHS. The following insurances are required for each waiver agency or direct service provider:

- Worker's compensation
- Unemployment
- Property and theft coverage
- Fidelity bonding (for persons handling cash)
- No-fault vehicle insurance (for agency-owned vehicles)
- General liability and hazard insurance (including facilities coverage)

MDHHS recommends the following insurances for additional agency protection:

- Insurance to protect the waiver agency or direct service provider from claims against waiver agency or direct service provider drivers and/or passengers
- Professional liability (both individual and corporate)
- Umbrella liability
- Errors and Omission Insurance for Board members and officers
- Special multi-peril
- Reinsurance/Stop-loss insurance

9.14 Volunteers

Each waiver agency or direct service provider utilizing volunteers must have a written procedure governing the recruiting, training, and supervising of volunteers. Volunteers must receive a written position description, orientation, training, and a yearly performance evaluation, if appropriate.

9.15 Staffing

Each waiver agency or direct service provider must employ competent personnel who have the necessary skills to provide quality supports and services to participants at levels sufficient to provide services pursuant to the contractual agreement. Each waiver agency or direct service provider must demonstrate an organizational structure including established lines of authority. Each direct service provider must identify a contact person with whom the waiver agency can discuss work orders and service delivery schedules or problems.

9.16 Staff Identification

Every waiver agency or direct service provider staff person, paid or volunteer, who enters a participant's home must display proper identification. Proper identification may consist of either an agency picture card or a Michigan driver's license and some other form of agency identification.

9.17 Orientation and Training Participation

New waiver agency or direct service provider staff must receive an orientation training that includes, at a minimum:

- Introduction to the MI Choice waiver;
- The waiver agency's grievance and appeal process;
- Maintenance of records and files (as appropriate);
- Emergency procedures;
- Assessment and observation skills; and
- Ethics, specifically:
  - Acceptable work ethics
  - Honoring the MI Choice participant's dignity
  - Respect of the MI Choice participant and their property
  - Prevention of theft of the MI Choice participant's belongings.

Employers must maintain records detailing dates of training and topics covered in employee personnel files.

Waiver agencies and/or direct service providers must ensure that each employee has the support and training needed to competently and confidently deliver services to participants prior to working with each participant. Waiver agency or direct service provider staff must participate in relevant in-service training as appropriate and feasible. Some MI Choice services have specific requirements for in-service training. When applicable, the service standard stipulates the required in-service training topics.

9.18 Record Retention

Each waiver agency and direct service provider must keep all records related to or generated from the provision of services to waiver participants for not less than 10 years.

9.19 Waiver Agent Billing and Payments

9.19.A. Billing Procedures

- Providers of MI Choice services submit bills to the waiver agency detailing the date of service, the type of service, the unit cost, and the total number of units provided for each MI Choice participant served.
- Waiver agencies specify in provider contracts the acceptable amount of time from date of service that providers may send bills to the waiver agency in order to receive payment for services rendered.
- Waiver agencies match and verify provider bills against the participant's approved PCSP using MICIS, COMPASS, or a compatible data system.
- Waiver agencies have written procedures regarding the billing process.

9.19.B. Provider Payments

- Waiver agencies process payment for all verified bills submitted by providers.
- Waiver agencies make payments only for services authorized within the PCSP and delivered to the participant.
- Waiver agencies submit MI Choice encounter data to CHAMPS electronically. Encounter data for MI Choice services meets CHAMPS requirements (including CHAMPS edits) for processing.
- The CHAMPS system records encounter data detail.
- Waiver agencies use MICIS, COMPASS, or compatible software to maintain an audit trail for funds expended.
- MICIS, COMPASS, or compatible software produces claims detailing provider and participant identification, date of service, specific procedure, and payment data.
- Waiver agencies have written procedures ensuring full payment to providers who furnish MI Choice services according to the authorized PCSP.

9.20 Compliance with Rules and Laws

9.20.A. Civil Rights Compliance

Each waiver agency or direct service provider must not discriminate against any employee or applicant for employment, or against any MI Choice applicant or participant, pursuant to the Federal Civil Rights Act of 1964, the Elliot-Larsen Civil Rights Act (P.A. 453 of 1976), and Section 504 of the Federal Rehabilitation Act of 1973. Each waiver agency or direct service provider must complete an appropriate Federal Department of Health and Human Services form assuring compliance with the Civil Rights Act of 1964.

Each waiver agency or direct service provider must clearly post signs at agency offices and public locations where services are provided in English, and other languages as appropriate, indicating non-discrimination in hiring, employment practices, and provision of services.

9.20.B. Nondiscrimination (Section 1557: Patient Protection and Affordable Care Act)

Section 1557 of the Patient Protection and Affordable Care Act (ACA) applies to the MI Choice program and provides that, except as provided in Title I of the ACA, an individual shall not, on the grounds prohibited under Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, or Section 504 of the Federal Rehabilitation Act of 1973, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under Title I of the ACA. This part applies to health programs or activities administered by recipients of Federal financial assistance from the Department, Title I entities that administer health programs or activities, and Department-administered health programs or activities.

9.20.C. Equal Employment

Each waiver agency and direct service provider must comply with equal employment opportunity principles in keeping with Executive Order 1979-4 and Civil Rights Compliance in state and federal contracts.

9.20.D. Drug Free Workplace

MDHHS prohibits the unlawful manufacture, distribution, dispensing, possession, or use of controlled substances in all waiver agency and direct service provider workplaces. Each waiver agency and direct service provider must operate in compliance with the Drug-Free Workplace Act of 1988.

9.20.E. Americans with Disabilities Act

Each program must operate in compliance with the Americans with Disabilities Act (PL 101-336).

9.20.F. Standard Precautions

Each waiver agency and direct service provider must evaluate the occupational exposure of employees to blood or other potentially infectious materials that may result from the employee's performance of duties. Each waiver agency and direct service provider must establish appropriate standard precautions based upon the potential exposure to blood or infectious materials. Each waiver agency and direct service provider with employees who may experience occupational exposure must also develop an exposure control plan that complies with the Federal regulations implementing the Occupational Safety and Health Act.

9.21 Provider Monitoring Requirements for Waiver Agencies

9.21.A. On-Site Provider Reviews

Waiver agency staff conducts annual on-site monitoring reviews for a minimum of 20% of enrolled providers of recurrent services. This includes adult day health, chore, community living supports, counseling, fiscal intermediary, home delivered meals, transportation, nursing facility transition, nursing services, personal emergency response systems, private duty nursing, in-home and out-of-home respite, supports coordination when not using agency employees, and training. This monitoring plan is to ensure:

Provider compliance to minimum service standards and conditions of participation. This includes compliance to the CMS regulations regarding home and community-based services settings as defined in 42 CFR §441.301(c)(4) and the Home and Community-Based Services Chapter of this Manual.

- Delivery of services according to the authorized MI Choice participant PCSP.
- Provider maintenance of adequate staff recruitment, training plans and staff supervision.
- Provider maintenance of participant case record documentation to support provider claims.

Waiver agency staff evaluates providers of non-recurrent services (durable medical equipment, medical supplies, goods and services, and home modifications) based on frequency and volume of usage at least once every two years to ensure:

- Provider compliance to minimum service standards and conditions of participation
- Delivery of services according to the authorized MI Choice participant PCSP
- Provider maintenance of participant case record documentation to support provider claims

9.21.B. Methodology

The waiver agency assigns one or two staff with primary responsibility for conducting provider reviews using the standardized monitoring tool developed for this purpose (refer to the Directory Appendix). The waiver agency notifies providers in writing at least two weeks in advance of the date scheduled for the review. The waiver agency selects a sample of 10 participant case records or 20% of the provider case records (whichever is greater) to evaluate. The waiver agency staff reviews three months of provider billings to payments for each case record. The waiver agency may choose to monitor more providers as necessary to ensure the quality of services delivered to MI Choice participants. Additionally, not included in the sample indicated above, the waiver agency must perform monitoring of 100% of provider-owned/controlled settings and must utilize the Residential and Non-residential surveys provided by MDHHS.

Provider records to review include participant case record documentation, service claims, and reimbursements. The waiver agency compares payment records to MI Choice person-centered service plan authorizations and MI Choice case record documentation.

Waiver agency reviewers evaluate provider records for date of service, time of service delivery, staff providing the service, supervision of staff providing the service, and any discrepancies noted during the review.

The waiver agency reviewers provide written findings of the review and corrective action requirements (as necessary) to the provider within 30 days following completion of the initial review. The waiver agency sends all provider monitoring reports to MDHHS within 30 days of completion of the monitoring process. The written review includes citations of both positive findings and areas needing corrective action.

When results of the initial case record/bill review indicate any irregularities, the reviewer and waiver agency financial staff conducts further review of provider case records covering a specified time. Waiver agency staff may opt to conduct a complete audit of all case records. Following a second review, a written report of the findings is prepared with appropriate corrective actions and sent to the provider and MDHHS within 30 business days following completion of the review. Waiver agency staff schedules a follow-up review within a three to six month timeframe for providers deficient in any part of the review to ensure that the provider initiates and implements corrective action.

Service issues/activities identified for corrective action require the waiver agency to:

- Clearly identify formal findings, state compliance issues, and provide recommendations for corrective action.
- Establish due dates when the provider is scheduled to be in full compliance with the standards and conditions for continued participation.
- Monitor the provider's performance in completing the necessary corrective action.
- Suspend new referrals to the provider agency or transfer participants to another provider when findings warrant immediate action to protect the participant's health or welfare.
- Adjust provider billings on the agency's information system using individual adjustments to date of service or gross adjustment. Deduct overpayments made to a provider from the next warrant issued the provider from the waiver agency. Adjust encounter data submitted to CHAMPS to accurately reflect adjustments made to provider billing.
- Suspend or terminate the providers who demonstrate a failure to correct deficiencies following a second review. The waiver agency can reinstate providers after verifying the provider corrected deficiencies and/or changed procedural practices as required.

Additionally, not included in the sample indicated above, the waiver agency must perform monitoring of 100% of provider-owned/controlled settings and must utilize the Residential and Non-Residential surveys provided by MDHHS. If the setting remains compliant, the waiver agency only needs to maintain the surveys in a file at the waiver agency. The waiver agency must send to MDHHS the completed home and community-based settings survey in the following circumstances:

- The setting is a new setting and has not had a previous survey completed and reviewed by MDHHS and deemed compliant.
- There has been a change in ownership for the setting.

- There have been major changes in how the setting operates their business.

The waiver agency notifies MDHHS immediately of any provider-owned setting that is no longer compliant with the home and community-based services settings regulations as assessed using the Residential Survey for MI Choice Waiver or the Non-Residential Survey for MI Choice Waiver as appropriate. Provider-owned settings include licensed and non-licensed assisted living, AFCs or Homes for the Aged, and adult day health providers. The notification will include the corrective action plan and timeline for implementing the corrective action plan. The waiver agency will be responsible for ensuring the corrective actions have been implemented in a subsequent in-person visit to the setting. The waiver agency will forward the results of the subsequent in-person visit to MDHHS within one to two weeks of completing the visit. The waiver agency will immediately notify MDHHS if the subsequent visit indicates the provider continues to be non-compliant with the ruling and will require MI Choice participants to transition from the setting.

9.21.C. In-Home Participant Visits

To gauge the effectiveness of service delivery accurately, it is necessary to obtain comments regarding service provision from the perspective of the participant and caregiver. From the sample of participant case records reviewed, the waiver agency reviewer selects a minimum of two waiver participants with which they shall conduct home visits. These visits determine participant satisfaction with supports coordination activities and services and verify that providers deliver services as planned.

The in-home visit may correspond to a time when the provider is working in the participant's home. The scheduling of a participant home visit in tandem with the actual service provision allows the waiver agency reviewer to observe the provider at work and the interaction between the worker and the participant. The reviewer interviews the provider to determine their understanding of the tasks they should perform as specified in the PCSP and MI Choice work order. The reviewer also verifies with the participant and caregiver that the provider is delivering services as planned.

The waiver agency reviewer ensures the participant's supports coordinator is aware of pertinent information such as concerns regarding service delivery that the reviewer gathers during the home visit interviews. Supports coordinators follow-up with participant concerns identified during the home visits.

For participants who reside in provider-owned settings (assisted living, AFC, HFA, etc.), waiver agencies complete the additional questions at the end of the participant survey. Any "No" answers provided by the participant (or their authorized representative) require follow-up with the provider to ensure continued compliance to the home and community based services setting requirements.

9.21.D. Coordination with Supports Coordinators

Before or immediately after conducting the on-site provider review, the waiver agency reviewer meets with supports coordinators to discuss utilization of the provider and any problems encountered in using the provider. Additionally, the waiver agency reviews

MI Choice participant case records and other documentation to evaluate the interaction with the provider and determine the frequency of "missed" visits or "no shows" by the provider as related to the plan of service and the MI Choice work order. The review of MI Choice case records assists the waiver agency reviewer to measure provider adherence to the authorized PCSP.

9.21.E. Coordination With Other Waiver Agencies

To the extent feasible and possible, waiver agencies should coordinate monitoring visits to providers that contract with more than one waiver agency. MDHHS encourages waiver agencies to combine efforts to monitor providers under contract with more than one waiver agency. Any time a waiver agency finds rationale to terminate a provider from the provider network, the waiver agency must notify other waiver agencies of the findings and the reason for terminating the contract. This is to mitigate potential harm to other MI Choice participants. Waiver agencies must also notify MDHHS of any contract terminations and the reasons for doing so.

9.21.F. Monitoring Schedule

The waiver agency develops a yearly schedule of provider monitoring reviews to conduct monthly throughout the fiscal year, October 1 to September 30. The schedule is submitted to MDHHS by December 1 each year.

9.22 Provider Enrollment in CHAMPS

Waiver agencies and providers must be compliant with all provider enrollment background and screening requirements as required by the MI Choice program. Any individual or entity that provides applicable MI Choice services and are included in a waiver agency's provider network are required to be screened and enrolled in the Michigan Medicaid Program. Individuals and entities are considered to be included in the provider network when they have a contract with a waiver agency to furnish any of the applicable services, or when they have a contract with a beneficiary enrolled in the MI Choice program to furnish services through a self-determination arrangement.

9.23 Provider Case Records

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

- Service work orders or authorizations.
- Assessment, parts or the entire assessment provided by the waiver agency.
- Types of services provided to each participant, i.e., a description of tasks completed by date of service, worker notes describing the tasks completed for each shift, and in-home service logs. Worker time sheets without tasks performed do not meet these criteria.
- Ranges of time that each service is provided (i.e., 10:00 a.m. – 12:00 p.m.); times are subject to change according to participant preferences and waiver agency authorization.
- Date of service delivery.
- Progress notes and supervisory notes.

- Identification of the worker providing each service and that worker's signature.

Additionally, providers are required to maintain the following:

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

SECTION 10 – PROGRAM QUALITY

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

Through the course of doing business, MDHHS may identify potential areas of concern with administration of the MI Choice program as specified in the contract between MDHHS and the waiver agency. This includes but is not limited to Clinical and Administrative Quality Assurance Reviews, receipt of complaints from participants or other stakeholders and partners and review of State Fair Hearing Decisions and Orders. MDHHS will investigate all issues to determine their scope. When the scope of an issue is widespread (meaning not isolated to a single participant, supports coordinator, or scenario) or has the potential to impinge upon the rights of participants or applicants, MDHHS will initiate a formal corrective action process. This process begins with identifying the scope of the issue identified and discussing the issue in person with the waiver agency. MDHHS or its designee may require corrective action from the waiver agency. Failure to implement a corrective action plan that addresses the issue identified may lead to implementation of sanctions as identified in the contract between MDHHS and the waiver agencies.

10.1 ADMINISTRATIVE QUALITY ASSURANCE REVIEWS

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

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

MDHHS notifies each waiver agency in writing of deficiencies requiring corrective action and provides a date for the waiver agency to provide a corrective action plan to MDHHS. In the event of a continued deficiency, MDHHS has the authority to take action toward the waiver agency, including the imposition of sanctions as defined in the MI Choice Contract. MDHHS has the option to suspend or terminate the Contract of any waiver agency that fails to correct stated deficiencies identified on a second review.

10.2 QUALITY MANAGEMENT PLANS

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

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

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

10.3 Clinical Quality Assurance Reviews

MDHHS contracts with an External Quality Assurance Review agency to conduct an annual Clinical Quality Assurance Review (CQAR) of each waiver agency. The review is to determine whether the authorized services in the person-centered service plan are sufficient to protect the health and welfare of the participant and to determine whether the waiver agency is abiding by the laws, rules, and regulations that govern the MI Choice program. The primary means of gathering information for the CQAR include reviewing case records and interviewing waiver agencies and participants.

Randomly selected records are reviewed. Samples are derived using federally-approved sampling techniques with a minimum of 10 records reviewed at each agency. In addition, a minimum of five home visits are conducted to verify information in the records. The review is conducted by a team of trained and qualified reviewers.

10.4 Critical Incident Response and Reporting

MI Choice is required to track and to report certain events that might indicate exceptional risk to the participant. Not only are these requirements defined in regulation, but also in law. A "critical incident" is any actual, alleged, or suspected event or situation that occurs as a result of abuse, neglect, exploitation, or any event that creates a significant or potential risk of substantial or serious harm to the physical or mental health, safety or well-being of a waiver participant.

10.4.A. Types of Critical Incidents and Serious Events

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

- Exploitation
- Illegal activity in the home with potential to cause a serious or major negative event
- Neglect
- Physical abuse
- Provider no-shows, particularly when the participant is bed-bound all day or there is a critical need for the service to be provided as indicated by a 1A, 1B, or 1C service need level and no successful backup plan
- Sexual abuse

- Theft – of anything
- Verbal abuse
- Worker consuming drugs/alcohol on the job
- Suspicious or unexplained death that the waiver agency, or other entity, reports to law enforcement and that is related to providing services, supports, or care
- Medication errors resulting in emergency medical treatment or hospitalization
- Injuries requiring medical treatment
- Restraints, seclusion or restrictive interventions
- Hospitalization or emergency department visits within 30 days of previous hospitalization due to neglect or abuse
- Other – other event that creates a significant or potential risk of substantial or serious harm to the physical or mental health, safety or well-being of a waiver participant not already listed (fire, drive by shooting, car accident, etc.).

10.4.B. Critical Incident Response

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

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

10.4.C. Critical Incident Reporting [Change Made 7/1/2026]

Waiver agencies are responsible for tracking and responding to individual critical incidents using the Critical Incident Reporting web-based system. The online system allows MDHHS to review the reports in real time and ask questions or address concerns with the waiver agencies. MDHHS must receive notification from waiver agencies of suspicious deaths within two business days. Waiver agencies submit critical incident reports to MDHHS Health Services, **(revised 7/1/2026)** Home and Community Based Services Section as they occur using the Critical Incident Management System.

Waiver agencies must require contracted providers to report unexpected deaths to the waiver agency within two business days of the unexpected death. For all other Critical Incidents, contracted providers must report to the waiver agency within 30 calendar days

of the Critical Incident. Once the waiver agency is notified of the Critical Incident, MDHHS requires waiver agencies to enter, report, and provide updates to critical incidents within two business days of the waiver agency becoming aware of the incident.

Once the waiver agency is notified of the Critical Incident, MDHHS requires waiver agencies to enter, report, and provide updates to critical incidents within two business days of the waiver agency becoming aware of the incident.

Waiver agencies report to MDHHS all critical incidents including:

- A description of each incident;
- Investigations and strategies implemented to reduce, ameliorate, and prevent future incidents from occurring; and
- Follow-up activities conducted through the resolution of each incident. Critical Incidents should be resolved within two months unless there are extenuating circumstances, or an investigation is ongoing. If the Critical Incident is not resolved within two months, the notes should be updated frequently until the Critical Incident is resolved.

SECTION 11 – GRIEVANCES AND APPEALS

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

MDHHS has established participant and provider appeal processes that are applicable to MI Choice. The participant appeals process conforms to the Medicaid fair hearing requirements found in federal law.

All Medicaid applicants and recipients have the right to a fair hearing. Waiver agencies, as a Medicaid managed care provider, have certain responsibilities related to the rights of persons applying for or receiving MI Choice services. This includes providing the applicant or participant with appropriate notice of their right to request an appeal when the waiver agency takes an adverse action against them, or a grievance when they are dissatisfied with the quality of services received. For applicants and participants of MI Choice, an adverse action occurs when, but is not limited to, situations where the waiver agency does any of the following:

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

Attachment C of the MI Choice Contract specifies requirements for the waiver agency's Grievance and Appeal system, including time frames for making decisions and the individual's right to a Medicaid Fair Hearing after exhausting the waiver agency's process.

11.1 PARTICIPANT GRIEVANCES

Waiver agencies must establish their own internal grievance process. Participants may file a grievance orally or in writing when they are dissatisfied with the quality of services received. A grievance may be submitted to the waiver agency at any time. Waiver agencies must address grievances according to the time frames and requirements set in federal law and in the MI Choice Contract.

11.2 PARTICIPANT INTERNAL APPEALS

Waiver agencies must establish their own internal appeal process for participants to file an appeal with the agency. The internal appeal process must conform to requirements and time frames set by federal law and the MI Choice Contract. The internal appeal process applies only to MI Choice enrolled participants and in the following situations:

- The waiver agency is denying a requested service that is not already in place,
- The waiver agency is terminating, suspending or reducing a service that is already in place,
- The waiver agency is taking action or making an adverse determination based on suspicion of fraud, or
- In areas with only one waiver agency, the denial of a participant's request to exercise their right to obtain services outside the network.

Waiver agencies must send the participant an Adverse Benefit Determination notice when making any of the adverse decisions listed above. The Adverse Benefit Determination notice must meet the requirements specified in federal law and the MI Choice Contract. CMS requires managed care providers to send an Adverse Benefit Determination notice to MI Choice participants when the waiver agency makes decisions regarding their access to MI Choice services. Each Adverse Benefit Determination sent to the participant must be in writing and meet the language needs of the individual so the recipient understands the content (i.e., the format meets the needs of those with limited English proficiency and/or limited reading proficiency). Participants have 60 calendar days from the date of the Adverse Benefit Determination to request an internal appeal.

If the internal appeal decision upholds the action described in the Adverse Benefit Determination and the participant remains unsatisfied, the participant or legal representative may request a State Fair Hearing.

When an applicant or participant does not meet the LOCD, waiver agencies will bypass the Internal Appeal process and provide the individual with the necessary State Fair Hearing request forms pertaining to LOCD. Waiver agencies must use the version of the State Fair Hearing request form (DCH-0092-MOAHR) with the "EDW-LOCD" code entered in the "State Program or Service being provided to this client" field. Waiver agencies must also utilize the Adequate Action Notices on the LOCD website instead of the Notice of Adverse Benefit Determination. Applicants or participants must be made aware that they have the option to request a Secondary Review as identified on the hearing notice.

11.3 State Fair Hearing

Applicants for MI Choice may request a State Fair Hearing when the waiver agency makes an adverse determination. MI Choice participants may request a State Fair Hearing when the waiver agency issues an internal appeal decision that upholds the action described in the Adverse Benefit Determination or when the waiver agency does not adhere to the time frames required for making a decision in an internal appeal.

Waiver agencies must provide adequate or advance notice to the applicant or participant that conforms to the requirements and time frames specified in federal law and the MI Choice Contract.

11.4 Provider and Waiver Agency Appeals

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

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