MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

MINIMUM OPERATING STANDARDS

FOR MI CHOICE SERVICES

Home and Community Based Services Waiver
For the Elderly and Younger Adults with Disabilities

October 1, 2017

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MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

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I. GENERAL OPERATING STANDARDS FOR WAIVER AGENCIES AND CONTRACTED DIRECT SERVICE PROVIDERS

Administering agencies of the MI Choice Waiver program and direct service providers must comply with all general program requirements established by the Michigan Department of Health and Human Services (MDHHS).

Required Program Components

A. Contractual Agreement

MI Choice waiver agencies may only administer the MI Choice waiver program through a formal contractual agreement between the waiver agency and MDHHS. Service providers may only deliver MI Choice waiver services through a formal subcontract agreement between the waiver agency and the service provider agency. Each subcontract must contain all applicable contract components required by MDHHS.

B. Compliance with Service Definitions

State and Federal funds awarded by MDHHS may only pay for those services that MDHHS has included and defined in the Centers for Medicare and Medicaid Services (CMS) approved waiver application, and for which MDHHS has defined minimum standards. Each waiver agency and direct service provider must adhere to the definition and minimum standards to be eligible to receive reimbursement of allowable expenses.

C. Person-Centered Planning Process

Waiver agencies and direct service providers must utilize a person-centered planning process and knowledge of person-centered planning must be evident throughout the delivery of services. This includes assessing the needs and desires of participants, developing service/support plans, and continuously updating and revising those plans, as the participant's needs and preferences change. Waiver agencies and direct service providers must implement person-centered planning in accordance with the MDHHS Person-Centered Planning Guideline.

D. Contributions

1. 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.

2. The waiver agency and each direct service provider must accept MI Choice payments for services as payment in full for such services.

3. 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.

E. 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 his or her 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.

F. Insurance Coverage

1. 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:

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

2. MDHHS recommends the following insurances for additional agency protection:

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

G. 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.

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H. 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.

I. 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.

J. Orientation and Training Participation

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

1. Introduction to the MI Choice waiver;
2. The waiver agency's grievance and appeal process;
3. Maintenance of records and files (as appropriate);
4. Emergency procedures
5. Assessment and observation skills; and
6. Ethics, specifically;
    a. Acceptable work ethics
    b. Honoring the MI Choice participant's dignity
    c. Respect of the MI Choice participant and their property
    d. 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.

K. 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 Acts 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.

L. **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.

M. **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.

N. **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.

O. **Americans with Disabilities Act**

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

P. **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 ten years.

Q. **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). Direct service providers with subcontracts secured prior to September 30, 2015 will have until March 17, 2019 to become fully compliant with this regulation. All direct service providers added to the waiver agency's provider network after September 30, 2015 must be compliant with this ruling before the direct service provider may furnish services to a waiver participant. Direct service providers who fail to become compliant with this regulation by March 17, 2022 will

be removed from the provider network and will not receive Medicaid reimbursement for services provided to MI Choice participants after March 17, 2022.
MDHHS will use the following process to ensure compliance to this requirement:

1) Each waiver agency will assess all applicable providers using the survey found in Attachment J of this contract. The results of the surveys will be submitted electronically to MDHHS for a determination of compliance to the requirements.
2) 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.
3) For providers who are non-compliant, the provider will have 90 days to correct all issues that cause the non-compliance.
4) Once the issues are corrected, the provider will notify the waiver agency and schedule another on-site survey.
5) The waiver agency will have 90 days to complete another on-site survey and submit the survey to MDHHS for review.
6) If a provider does not contact the waiver agency within 90 days, the waiver agency will contact the provider to determine progress on the corrective action and schedule another on-site visit accordingly.
7) 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.
8) Some providers may require Heightened Scrutiny to determine compliance. These providers will follow the Heightened Scrutiny Process defined by MDHHS to assure compliance and to continue participation with the MI Choice program.
9) Regardless of the original notification date, all providers in all MI Choice provider networks will be compliant with the ruling no later than September 30, 2021, or the date approved in the State Transition Plan, whichever is sooner.
10) Waiver agencies will start transition plans with individuals served by non-compliant providers as of October 1, 2021. This planning will be person-centered and will focus on meeting the wishes of each participant regarding their preference of a qualified provider and enrollment in the MI Choice program.
11) By March 17, 2022, 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.

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Minimum Operating Standards for MI Choice Waiver Program Services

II. GENERAL OPERATING STANDARDS FOR MI CHOICE WAIVER PROVIDERS

In addition to the general operating standards for MI Choice waiver agencies and their contracted direct service providers, the following general standards apply to all entities providing either home-based or community-based MI Choice waiver services, as applicable, unless otherwise specified.

A. Home-Based Service 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, nursing services, counseling, home delivered meals, training, and nursing facility transition services.

1. Charging for MI Choice Services

   Waiver agencies and direct service providers must not charge participants a fee to receive MI Choice waiver services.

2. Participant Assessments

   Each waiver agency must complete the state-approved assessment instrument for each participant according to established standards before initiating service. 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. 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.

3. Service Need Level

   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 assure 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.

   a. 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

   b. Availability of Informal Supports
      A. No informal supports are available for the participant
      B. Informal supports are available for the participant
      C. The participant resides in a supervised residential setting

c. Grid of Service Need Levels

Immediacy	Informal Supports	Service Need Level	Service Need Level Description
Immediate	None	1A	This means you cannot be left alone. If your services are not delivered as planned, your backup plan needs to start immediately.
Immediate	Available	1B	This means you cannot be left alone. If your services are not delivered as planned, your family or friends need to be contacted immediately.
Immediate	SRS	1C	This means you cannot be left alone. Staff at your place of residence must be available to you as planned or follow established emergency procedures.
Urgent	None	2A	This means you can be left alone for a short time. If your services are not delivered as planned, your backup plan needs to start within 12 hours.
Urgent	Available	2B	This means you can be left alone for a short time. If your services are not delivered as planned, your family or friends need to be contacted within 12 hours.
Urgent	SRS	2C	This means you can be left alone for a short time. Staff at your place of residence must check on you periodically each day. Follow established emergency procedures if no staff is present in the home.
Routine	None	3A	This means you can be left alone for a day or two. If your services are not delivered as planned, your backup plan needs to start within a couple of days.
Routine	Available	3B	This means you can be left alone for a day or two. If your services are not delivered as planned, your 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. Person-Centered Service Plans

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:

a. The individual chose the setting in which he or she resides
b. The services and supports that are important to the individual to meet the needs identified during the individual's assessment
c. The individual's strengths and preferences
d. The clinical and support needs identified by a functional assessment
e. The amount of service authorized
f. The frequency and duration of each service, and the individual's preference for receiving those services and supports
g. The type of provider to furnish each service
h. Participant focused goals and outcomes
i. 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
j. Risk factors and measures identified to mitigate them
k. Individuals responsible for monitoring the plan
l. The informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation

5. Supervision of Direct-Care Workers

Home-based service providers must have a supervisor available to direct care workers at all times 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.

6. Participant Records

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

a. Details of the request to provide services.
b. 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).
c. Service authorizations or work orders.
d. 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.
e. Notes in response to participant, family, and agency contacts (not required for home delivered meal programs).
f. 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 ten years.

7. 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 his or her 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.

8. 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 service. 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. Reference and Criminal History Screening Checks

Each waiver agency and direct provider of home-based services must require and thoroughly check references of paid staff that will enter participant homes. In addition, each waiver agency and direct provider of home-based services must conduct a criminal history screening through the Michigan State Police for each paid and volunteer staff person who will be entering participant homes. The waiver agency and direct provider must conduct the reference and criminal history screening checks before authorizing the employee to furnish services in a participant's home.

10. 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:

a. 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.
b. Direct service workers are prohibited from smoking in participant's homes.
c. 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 properly use cleaning and cooking products.)

d. Direct service workers must not threaten or coerce participants in any way. Failure to meet this standard is grounds for immediate discharge.
e. Waiver agencies will inform service contractors and direct service workers promptly of new service standards or any changes to current services standards.

B. Community-Based Service Providers

MI Choice waiver community-based services include; environmental accessibility adaptations, respite services provided outside of the home, specialized medical equipment and supplies, transportation, and adult day health.

1. Adherence to Standards

   Direct providers of community-based services must adhere to standards 1-4 of the home-based service provider standards.

2. Participant Records

   Each direct provider of community-based services must maintain participant records that contain, at a minimum:

   a. A copy of the request for services.
   b. Pertinent and necessary medical, social, and functional participant information to assure the proper delivery of the requested service.
   c. A description of the provided service, including the number of units and cost per unit, as applicable.
   d. The date(s) of service provision.
   e. The total cost of each service provided.

   Direct providers of community-based services must keep all participant records (written, electronic, or other) confidential in controlled access files for at least ten years.

3. Notifying Participant of Rights

   Each waiver agency or direct provider of community-based services must notify each participant, in writing, at the initiation of service of his or her 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.

4. Reference and Criminal History Checks

   Each waiver agency and direct provider of community-based services must require and thoroughly check references of paid staff that will enter participant homes. In addition, each waiver agency and direct provider of community-based services must conduct a criminal history screening through the Michigan State Police for each paid and volunteer staff person who will be entering participant homes. The waiver agency and direct provider must conduct the reference and criminal history screening checks before authorizing the employee to furnish services in a participant's home.

C. Self-Determined Service 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 living supports, environmental accessibility adaptations, fiscal intermediary, goods and services, transportation, private duty nursing, respite services provided inside the participant's home, and respite services provided in the home of another.

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.

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.

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.

4. Provider Qualifications

   Providers of self-determined services must minimally:

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

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III. SPECIFIC OPERATING STANDARDS FOR MI CHOICE WAIVER SERVICE PROVIDERS

The following pages describe specific operating standards for each waiver service. These standards apply to each provider interested in furnishing the particular service to MI Choice participants. The waiver agency must authorize the provision of each service to waiver participants. Waiver agencies will not use MI Choice funds to pay for services not specifically authorized in advance and included in the participant's PCSP.

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NAME	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 must 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. 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, the waiver agency may separately authorize transportation to and from the Adult Day Health Center.
HCPCS CODES	**S5100**, Day care services, adult, per 15 minutes **S5101**, Day care services, adult, per half day **S5102,** Day care services, adult, per diem
UNITS	S5100 = 15 minutes S5101 = half day, as defined by waiver agency and provider S5102 = per diem
SERVICE DELIVERY OPTIONS	☑ Traditional/Agency-Based ☐ Self-Determination

Minimum Standards for Traditional Service Delivery

1. Each direct service provider must have written policies and procedures compatible with the "General Operating Standards for Waiver Agencies and Contracted Direct Service Providers", and minimally, Section B of the "General Operating Standards for MI Choice Waiver Providers."

2. Waiver agencies must only authorize Adult Day Health services for participants who meet at least one of the following criteria:

   a. Participants must require regular supervision to live in their own homes or the homes of a relative.

   b. Participants with caregivers must require a substitute caregiver while their regular caregiver is at work, in need of respite, or otherwise unavailable.

   c. Participants must have difficulty performing activities of daily living (ADLs) without assistance.

   d. Participants must be capable of leaving their residence with assistance to receive service.

   e. 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.

3. 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.

4. Each program must maintain comprehensive and complete files that include, at a minimum:

   a. Details of the participant's referral to the adult day health program,
   b. Intake records,
   c. A copy of the MI Choice assessment (and reassessments),
   d. A copy of the MI Choice PCSP,
   e. Listing of participant contacts and attendance,
   f. Progress notes in response to observations (at least monthly),
   g. Notation of all medications taken on premises, including:
      i. The medication;
      ii. The dosage;
      iii. The date and time of administration;
      iv. The initials of the staff person assisting with administration; and
      v. Comments
   h. Notation of basic and optional services provided to the participant,
   i. Notation of all releases of information about the participant, and
   j. A signed release of information form.

   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.

5. 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.

   a. Transportation.
   b. Personal Care.
   c. 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 eight to fourteen 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.
   d. 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.

6. 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.

   a. Rehabilitative: Physical, occupational, speech, and hearing therapies provided by licensed professionals under order from a physician.
   b. Medical Support: Laboratory, X-ray, or pharmaceutical services provided by licensed professionals under order from a physician.
   c. Services within the scope of the Nursing Practice Act (PA 368 of 1978).
   d. Dental: Under the direction of a dentist.
   e. Podiatric: Provided or arranged for under the direction of a physician.
   f. Ophthalmologic: Provided or arranged for under the direction of an ophthalmologist.
   g. Health counseling.
   h. Shopping assistance/escort.

7. 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:

   a. Written consent from the participant or participant's representative, to assist in taking medications.
   b. Verification of the participant's medication regimen, including the prescriptions and dosages.
   c. 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.
   d. Procedures for medication set up.
   e. Secure storage of medications belonging to and brought in by participants.
   f. Disposal of unused medications for participants that no longer participate in the program.
   g. Instructions for entering medication information in participant files, including times and frequency of assistance.

8. 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 ten 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 other individual or organization.

9. The provider must require staff to participate in orientation training as specified in the General Operating Standards for Waiver Agencies and Contracted Direct Service Providers. Additionally, program staff must have basic first-aid training.

10. The provider must require staff to attend in-service training at least twice each year. The provider must design this training specifically to increase their knowledge and understanding of the program and participants, and to improve their skills at tasks performed in the provision of service. The provider must maintain records that identify the dates of training, topics covered, and persons attending.

11. 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:

    a. The Secretary of State must appropriately license all drivers and vehicles and all vehicles must be appropriately insured.
    b. 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.
    c. All paid drivers must be trained to cope with medical emergencies unless expressly prohibited by a labor contract.
    d. Each program must operate in compliance with P.A. 1 of 1985 regarding seat belt usage.

12. 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 CPR, present at all times when participants are at the program site.

13. 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.

14. Each day care center must have the following furnishings:

    a. At least one straight back or sturdy folding chair for each participant and staff person.
    b. Lounge chairs or day beds as needed for naps and rest periods.
    c. Storage space for participants' personal belongings.
    d. Tables for both ambulatory and non-ambulatory participants.
    e. A telephone accessible to all participants.
    f. Special equipment as needed to assist persons with disabilities.

    The provider must maintain all equipment and furnishings used during program activities or by program participants in safe and functional condition.

15. Each day care center must document that it is in compliance with:

    a. Barrier-free design specification of Michigan and local building codes.
    b. Fire safety standards.
    c. Applicable Michigan and local public health codes.

Limitations:

1. Participants cannot receive Community Living Supports while at the Adult Day Health facility. Payment for Adult Day Health Services includes all services provided while at the facility. Community Living Supports may be used in conjunction with Adult Day Health services, but cannot be provided at the exact same time.
2. Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first.

3. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

4. HCPCS codes S5101 and S5102 are limited to one unit per day.

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Minimum Operating Standards for MI Choice Waiver Program Services

NAME	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 proprietor, pursuant to the lease agreement, will be examined prior to any authorization of service.
HCPCS CODES	**S5120**, Chore services; per 15 minutes **S5121**, Chore services; per diem
UNITS	S5120 = 15 minutes S5121 = Per diem
SERVICE DELIVERY OPTIONS	☑ Traditional/Agency-Based ☑ Self-Determination

Minimum Standards for Traditional Service Delivery

1. Each direct service provider must have written policies and procedures compatible with the "General Operating Standards for Waiver Agencies and Contracted Direct Service Providers," and minimally, Section A of the "General Operating Standards for MI Choice Waiver Service Providers."

2. 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.

3. Only properly licensed suppliers may provide pest control services.

4. Each waiver agency must develop working relationships with the Home Repair and Weatherization service providers, as available, in their program area to ensure effective coordination of efforts.

Minimum Standards for Self-Determined Service Delivery

1. Each chosen provider must minimally comply with Section C of the "General Operating Standards for MI Choice Waiver Service Providers."

2. Providers must have previous relevant experience and/or training for the tasks specified and authorized in the PCSP.

3. The waiver agency must deem the chosen provider capable of performing the required tasks.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Minimum Operating Standards for MI Choice Waiver Program Services

Service Limitations:

1. Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first.

2. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Minimum Operating Standards for MI Choice Waiver Program Services

NAME	Community Living Supports
DEFINITION	Community Living Supports facilitate an individual's independence and promote participation in the community. Community Living Supports can be provided in the participant's residence or in community settings. Community Living Supports include assistance to enable program participants to accomplish tasks that they would normally do for themselves if able. The services may be provided on an episodic or a continuing basis. The participant oversees and supervises individual providers on an on-going basis when participating in self-determination options. These services are provided only in cases when neither the participant nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision. When transportation incidental to the provision of community living supports is included, it must not also be authorized as a separate waiver service for the beneficiary.
HCPCS CODES	**H2015**, Comprehensive community support services, per 15 minutes **H2016**, Comprehensive community support services, per diem
UNITS	H2015 = 15 minutes H2016 = Per diem
SERVICE DELIVERY OPTIONS	☑ Traditional/Agency-Based ☑ Self-Determination

Minimum Standards for Traditional Service Delivery

1. Each direct service provider must have written policies and procedures compatible with the "General Operating Standards for Waiver Agencies and Contracted Direct Service Providers," and minimally, Section A of the "General Operating Standards for MI Choice Waiver Service Providers."

2. Community Living Supports (CLS) include:
   a. Assisting, reminding, cueing, observing, guiding and training in the following activities:
      i. Meal preparation
      ii. Laundry
      iii. Routine, seasonal, and heavy household care and maintenance
      iv. Activities of daily living such as bathing, eating, dressing, and personal hygiene
      v. Shopping for food and other necessities of daily living

   b. Assistance, support, and guidance with such activities as:
      i. Money management
      ii. Non-medical care (not requiring nursing or physician intervention)
      iii. Social participation, relationship maintenance, and building community connections to reduce personal isolation
      iv. Transportation from the participant's residence to community activities, among community activities, and from the community activities back to the participant's residence
      v. Participation in regular community activities incidental to meeting the individual's community living preferences
      vi. Attendance at medical appointments
      vii. Acquiring or procuring goods and services necessary for home and community living

c. Reminding, cueing, observing, and monitoring of medication administration

d. Staff assistance with preserving the health and safety of the individual in order that he or she may reside and be supported in the most integrated independent community setting.

e. Training or assistance on activities that promote community participation, such as using public transportation or libraries, or volunteering.

f. Dementia support, including but not limited to redirection, reminding, modeling, socialization activities, and activities that assist the participant as identified in the individual's person-centered plan.

g. Observing and reporting to the supports coordinator any changes in the participant's condition and the home environment.

3. When the CLS services provided to the participant include tasks specified in 2.a.i, 2.a.ii, 2.a.iii, 2.a.v, 2.b.i, 2.b.iii, 2.b.v, 2.b.vi, 2.b.vii, 2.d, or 2g above, the individual 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.

4. When the CLS services provided to the participant include tasks specified in 2.a.iv, 2.b.ii, 2.c, 2.d, 2.e, 2.f, or 2.g above, the direct service providers furnishing CLS must also:

   a. Be supervised by a registered nurse (RN) licensed to practice nursing in the State. 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.

   b. Develop in-service training plans and assure 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.

   c. 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 assure each workers confidence and competence in the performance of each task required.

   d. MDHHS strongly recommends each worker delivering CLS services complete a certified nursing assistant training course, first aid, and CPR training.

5. When the CLS services provided to the participant include transportation described in 2.b.iv the following standards apply:

a. Waiver agencies may not use waiver funds to purchase or lease vehicles for providing transportation services to waiver participants.

b. The Secretary of State must appropriately license and inspect all drivers and vehicles used for transportation supported all or in part by MI Choice funds. The vehicle owner must assure all vehicles used to transport participants have liability insurance.

c. 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.

d. 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.

e. Each provider must operate in compliance with P.A. 1 of 1985 regarding seat belt usage.

6. Waiver agencies authorize CLS when necessary to prevent the institutionalization of the participant served.

7. Individuals providing CLS must be at least 18 years old, have the ability to communicate effectively both orally and in writing and follow instructions.

8. 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.

9. Family members who provide CLS must meet the same standards as providers who are unrelated to the individual.

10. 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 assure that each worker competently and confidently performs every task assigned for each participant served.

11. Each direct service provider who chooses to allow staff to assist participants with self-medication, as described in 2.c above, 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:

a. 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.

b. Verification of prescription medications and their dosages. The participant must maintain all medications in their original, labeled containers.

c. Instructions for entering medication information in participant files.

d. 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.

12. CLS providers may only administer medications in compliance with Michigan Administrative Rule 330.7158:

a. 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.

b. A provider must assure that medication use conforms to federal standards and the standards of the medical community.

c. A provider must not use medication as punishment, for the convenience of the staff, or as a substitute for other appropriate treatment.

d. A provider must review the administration of a psychotropic medication periodically as set forth in the participant's individual PCSP and based upon the participant's clinical status.

e. If an individual cannot administer his or her own medication, a provider must ensure that medication is administered by or under the supervision of personnel who are qualified and trained.

f. A provider must record the administration of all medication in the recipient's clinical record.

g. 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.

Additional Standards for Participants Who Reside in Licensed Settings

1. CLS provided in a licensed setting 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.

2. Documentation in the participant's record must clearly identify the participant's need for additional supports and services not covered by licensure.

3. The PCSP must clearly identify the portion of the participant's supports and services covered by CLS.

4. Homemaking tasks incidental to the provision of assistance with activities of daily living may also be included in CLS, but must not replace usual and customary homemaking tasks required by licensure.

Minimum Standards for Self-Determined Service Delivery

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Minimum Operating Standards for MI Choice Waiver Program Services

1. When authorizing Community Living Supports for participants choosing the self-determination option, waiver agencies must comply with items 2, 5, 6, 7, 8, 9, and 12 of the Minimum Standards for Traditional Service Delivery specified above.

2. Each chosen provider must minimally comply with Section C of the "General Operating Standards for MI Choice Waiver Service Providers."

3. Each chosen provider furnishing transportation as a component of this service must have a valid Michigan driver's license.

4. When the CLS services provided to the participant include tasks specified in 2.a.i, 2.a.ii, 2.a.iii, 2.a.v, 2.b.i, 2.b.iii, 2.b.v, 2.b.vi, 2.b.vii, 2.d, or 2g above, the individual 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.

5. When the CLS services provided to the participant include tasks specified in 2.a.iv, 2.b.ii, 2.c, 2.d, 2.e, 2.f, or 2.g above, 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.

Limitations

1. Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first.

2. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

3. CLS does not include the cost associated with room and board.

4. 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.

5. CLS services cannot be provided in circumstances where they would be a duplication of services available under the state plan or elsewhere.

6. CLS excludes nursing and skilled therapy services.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Minimum Operating Standards for MI Choice Waiver Program Services

NAME	Community Transition Services
DEFINITION	Community Transition Services (CTS) are non-reoccurring expenses for persons transitioning from a nursing facility to another living arrangement in a private residence where the person is responsible for his or her own living arrangement.
HCPCS CODES	**T1023** Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter **T1028** Assessment of home, physical and family environment, to determine suitability to meet participant's medical needs **T2038** Community Transition, waiver; per service
UNITS	T1023 and T1028, per encounter T2038, per service
SERVICE DELIVERY OPTIONS	☑ Traditional/Agency-Based ☐ Self-Determination

Note: This service standard is applicable to the MI Choice program and nursing facility transition agencies approved by MDHHS to use special funding to perform nursing facility transitions. The term "transition agency" refers to both MI Choice waiver agencies and Centers for Independent Living.

Minimum Standards for Traditional Service Delivery

1. Waiver agencies or direct service providers must minimally comply with the following:

    a. Have written policies and procedures compatible with the "General Operating Standards for Waiver agencies and Contracted Direct Service Providers."
    b. Waiver agencies furnishing services defined under HCPCS codes T1023, T1028, or coordination and support through HCPCS code T2038 must also minimally comply with Section A of the "General Operating Standards for MI Choice Waiver Providers."
    c. Waiver agencies furnishing services defined under HCPCS code T2038 with the exception of coordination and support must minimally comply with Section B of the "General Operating Standards for MI Choice Waiver Providers."

2. Transition agencies may obtain some items directly from a retail store that offers the item to the public (i.e. Wal-Mart, K-mart, Meijer, Costco, etc.). When utilizing retail stores, the transition agency must assure the item purchased meets the service standards. The transition agency may choose to open a business account with a retail store for such purchases. The transition agency must maintain the original receipts and maintain accurate systems of accounting to verify the specific participant who received the purchased item.

3. Transition agencies must make the following assurances to MDHHS:

    a. Transition agencies must utilize a person-centered planning process and knowledge of person-centered planning must be evident throughout the delivery of services. This includes assessing the needs and desires of participants, developing service/support plans, and continuously updating and revising those plans, as the participant's needs change. Transition agencies must implement person-centered planning in accordance with the MDHHS Person-Centered Planning Guideline.

b. Each transition agency 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 his or her 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 participant information) so long as access is in conformity with the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996. Transition agencies and direct service providers must maintain all participant information in controlled access files. This requirement applies to all protected information whether written, electronic, or oral.

c. Each transition agency that utilizes 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.

d. Each transition agency provider must keep all records related to or generated from the provision of community transition services to participants for not less than six years.

4. For nursing facility residents who successfully transition to the community **and** enroll in the MI Choice program, services provided while residing in the nursing facility are not complete until the first date of waiver eligibility. Therefore, for billing purposes, all community transition services provided before MI Choice enrollment will have a date of service equal to the first date of MI Choice enrollment. The MI Choice case record must accurately reflect dates of service provision.

5. The document "Nursing Facility Transition Program Requirements and Guidelines" provides additional clarification regarding how to bill for CTS and is included as Attachment L of the MI Choice contract. Transition agencies must refer to that document for instructions regarding specific items covered as CTS.

6. The transition agency must bill the initial assessment of the nursing facility resident under HCPCS code T1023. The transition agency should use this HCPCS code only once per transition. The cost of this service includes supports and coordination provided during the initial assessment. HCPCS code T1023 is a per encounter code. When the transition agency submits claims for this code, the unit must be one and the cost per unit must equal the total cost.

7. The transition agency must bill assessments of potential domiciles using HCPCS code T1028. The transition agency may use this code more than once per transition, **but the federal government limits use to one unit per day.** The cost of this service includes supports and coordination provided by a knowledgeable health professional (i.e. physical therapist or occupational therapist) during the assessment of the potential domicile. HCPCS code T1028 is a per encounter code. **This health professional cannot be a paid staff member of the transition agency. When transition agency staff provides the assessment of the home, this is a part of the monthly coordination and support fee, whether the staff person is the primary transition coordinator or not.**

8. When a waiver agency authorizes more than one potential home assessment for a MI Choice participant per transition, the units must equal no more than one per day, regardless of the number

of assessments completed. The cost must equal the total cost of all assessments, up to the approved amount as specified in Attachment L.

9. The transition agency must bill all other transition services using HCPCS code T2038 with the appropriate standard remark for each transition service. A listing of standard remarks is available from a MI Choice contract manager and included in Attachment L of this contract. When a transitioning participant requires a transition service that does not have an appropriate standard remark, the transition agency must contact its contract manager for assistance. Waiver agencies must bill services or report encounters under HCPCS code T2038 that are provided after the first date of MI Choice enrollment using the date of service delivery as the billed date of service.

10. When a transition agency anticipates that a nursing facility resident receiving CTS will require MI Choice services in the community, the transition agency must immediately contact the appropriate waiver agency. The waiver agency will assess the individual to determine if the nursing facility resident appears to meet MI Choice eligibility requirements. If the waiver agency confirms the nursing facility resident appears to meet MI Choice eligibility requirements and the nursing facility resident desires to enroll in the MI Choice program upon transition, the case must be transferred to the MI Choice waiver agency. **CMS requires a waiver agency to authorize all CTS to persons expected to enroll in MI Choice upon transition. Therefore, a waiver agency or entity under contract with a waiver agency must perform all transition activity for a nursing facility resident expected to enroll in MI Choice upon transition.**

11. Using a person-centered planning process, the transition agency must develop a transition plan that includes all projected transition costs, participant goals, and is based on individual needs. This transition plan becomes part of the participant's case record maintained by the transition agency. Requirements for the transition plan are included in Attachment L.

12. The transition agency must notify MDHHS of persons it plans to transition from a nursing facility by completing a *Nursing Facility Transition Notice* in the Nursing Facility Transition portal. The transition agency must notify its MI Choice contract manager of persons it plans to transition from a nursing facility as soon as the transition agency identifies such persons.

13. All transition agencies must notify MDHHS of the participant's date of transition to the community, or reason for not completing the transition process with the participant using the Nursing Facility Transition portal.

14. When a nursing facility resident desires placement in the community outside of the Provider Service Area (PSA) of the transition agency in the same PSA as the nursing facility, the transition agency in the nursing facility PSA must contact the preferred community PSA transition agency. Each transition agency must coordinate efforts to assure a successful community transition for the nursing facility resident. If MI Choice enrollment is expected, the community waiver agency must hold a slot for that resident. Both transition agencies may share the NFT service costs, as necessary, to the extent that the transition agencies do not duplicate such costs.

15. When a NFT participant requires a home modification (also known as an environmental accessibility adaptation), the modification must follow the MI Choice Environmental Accessibility Adaptation service standards.

16. Transition agencies must submit a complete and accurate "Non-Waiver Funded Nursing Facility Transition Services Expenditure Report" for CTS claims when transitioned persons do not enroll in the MI Choice program. The transition agency must complete at least one report for each transitioned person upon completion of the transition process. The transition agency will not receive reimbursement for CTS until the contract manager receives a completed report including an original signature, and assures the transition agency has made all required submissions to the Nursing Facility Transition portal, and MDHHS approved those submissions.

Limitations

1. Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first.

2. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access CTS.

3. CTS does not include ongoing monthly rental or mortgage expense, regular utility charges, or items that are intended for purely diversional and recreational purposes.

4. For persons expected to enroll in MI Choice, when a transitioning participant requires a home modification (ramp, widened doorways, etc.) before the transition can take place, the waiver agency must authorize only those modifications immediately necessary for community transition as CTS. The waiver agency must authorize all other needed modifications as Environmental Accessibility Adaptation services or Chore services, as appropriate.

5. The transition agency must begin CTS no more than six months before the expected discharge from the nursing facility. If the transition agency will not complete the transition process within six months of the initial assessment, the transition agency must request an exception in the NFT Portal to continue working with the participant and extend the transition period.

6. Within 21 days of the date of transition to the community, transition agencies should identify and include in the transition plan all CTS items required to complete the transition. The transition agency will need to discuss items identified after this date with MDHHS to assure justification as a transition expense.

7. Transition agencies must complete supports coordination and follow along services within six months after the date of transition for persons not enrolling in the MI Choice program. Transition agencies may request an extension if the NFT participant has unique circumstances that require additional support and coordination efforts. MDHHS will consider such extension requests upon receipt of the request. Transition agencies must submit such requests as an exception through the Nursing Facility Transition portal.

8. Attachment L of the contract between MDHHS and the transition agencies identifies additional limitations on the amount, frequency, or duration of services.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Minimum Operating Standards for MI Choice Waiver Program Services

NAME	Counseling Services
DEFINITION	Professional level counseling services seek to improve the participant's emotional and social well-being through the resolution of personal problems and/or change in an individual's social situation.
CPT CODE	**99510**, Home visit for individual, family, or marriage counseling
UNITS	One visit, regardless of duration.
SERVICE DELIVERY OPTIONS	☑ Traditional/Agency-Based ☐ Self-Determination

Minimum Standards for Traditional Service Delivery

1. Each direct service provider must have written policies and procedures compatible with the "General Operating Standards for Waiver Agencies and Contracted Direct Service Providers," and minimally, Section A of the "General Operating Standards for MI Choice Waiver Providers."

2. Waiver agencies must only authorize counseling services for participants within one of the following groups:
   a. Individuals who are experiencing emotional distress or a diminished ability to function; or

   b. Adults, children, spouses, or other responsible relatives (e.g. sibling, niece, or nephew) who are appropriate for family counseling to resolve the problems of the waiver participant.

3. Providers receiving waiver funds for counseling services must provide the following service components, at a minimum:
   a. Psychosocial evaluation to determine appropriateness of counseling options.

   b. Treatment plan that states goals and objectives, and projects the frequency and duration of service.

   c. Individual, family, and/or group counseling sessions.

   d. Home visits and on-site counseling.

   e. Case conferencing with a waiver supports coordinator at least once every six weeks with participant's release.

4. Persons providing counseling services must have:
   a. A master's degree in social work, psychology, psychiatric nursing, or counseling, or

   b. 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, AND

   c. Be licensed in the State of Michigan to provide counseling under MCL 333.17201, MCL 333.18101, MCL 333.18201, or MCL 333.18501.

5. Each waiver agency will verify the licensure of each prospective counselor.

6. Counselors must maintain ongoing case files for each participant, recording the needs assessed, a treatment plan, and the progress achieved at each session.

Limitations

1. Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first. This includes mental health treatment and therapy available through community mental health agencies. Under no circumstances does MI Choice counseling replace therapeutic treatments available through the local community mental health agency.

2. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Minimum Operating Standards for MI Choice Waiver Program Services

NAME	Environmental Accessibility Adaptations
DEFINITION	Environmental Accessibility Adaptations (EAA) includes physical adaptations to the home required by the participant's PCSP that are necessary to ensure the health and welfare of the participant or that enable the participant to function with greater independence in the home, without which the participant would require institutionalization. Assessments and specialized training needed in conjunction with the use of such environmental adaptations are included as a part of the cost of the service.
HCPCS CODE	**S5165**, Home modifications, per service
UNITS	One modification or adaptation
SERVICE DELIVERY OPTIONS	☑ Traditional/Agency-Based ☑ Self-Determination

Minimum Standards for Traditional Service Delivery

1. All providers of EAA must meet the licensure requirements as outlined in MCL 339.601, MCL 339.2401, and/or MCL 339.2412, as appropriate.

2. Each direct service provider must have written policies and procedures compatible with the "General Operating Standards for Waiver Agencies and Contracted Direct Service Providers," and minimally, Section B of the "General Operating Standards for MI Choice Waiver Providers."

3. Adaptations may include:
   a. The installation of ramps and grab bars;
   b. Widening of doorways;
   c. Modification of bathroom facilities;
   d. Modification of kitchen facilities;
   e. Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the participant; and
   f. Environmental control devices that replace the need for paid staff and increase the participant's ability to live independently, such as automatic door openers.

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

5. Each waiver agency must develop working relationships with the weatherization, chore, and housing assistance service providers, as available in the program area to ensure effective coordination of efforts.

6. The participant, with the direct assistance of the PAHP 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. The participant's record must include evidence of efforts to apply for alternative funding sources and

the acceptances or denials of these funding sources. The MI Choice waiver is a funding source of last resort.

7. 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.

8. The waiver agency may not approve EAA for rental property without close examination of the rental agreement and the proprietor's responsibility (including both legal and monetary) to furnish such adaptations.

9. Adaptations may be made to rental properties when the lease or rental agreement does not indicate 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 PAHP must specify any requirements for restoration of the property to its original condition if the occupant moves.

10. The waiver agency must obtain a written agreement with the participant residing in each domicile to be modified that includes, at a minimum; a) a statement that the domicile is occupied by and is the permanent residence of the participant, and b) a description of the planned modifications.

11. 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.

12. The direct service provider must check each domicile for compliance with local building codes.

13. The waiver agency may not approve repairs, modifications, or adaptations to a condemned structure.

14. The PAHP must assure there is a signed contract or bid proposal with the builder or contractor prior to the start of an EAA.

15. It is the responsibility of the PAHP to work with the participant and builder or contractor to ensure the work is completed as outlined in the contract or bid proposal.

16. All services must be provided in accordance with applicable state or local building codes.

17. 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

18. Within fourteen calendar days or ten working days of completion, each waiver agency must utilize a job completion procedure which includes, at a minimum:

a. Verification that the work is complete and correct.
b. Verification by a local building inspector(s) that the work satisfies building codes (as appropriate).
c. Acknowledgment by the participant that the work is acceptable.

Minimum Standards for Self-Determined Service Delivery

1. When authorizing EAA for participants choosing the self-determination option, waiver agencies must comply with item 1 and items 3 through 17 of the Minimum Standards for Traditional Service Delivery specified above.

2. Each chosen provider must minimally comply with Section C of the "General Operating Standards for MI Choice Waiver Service Providers," except item 4.c regarding universal precautions and blood-borne pathogens.

Limitations

1. Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first.

2. 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. If it appears that another resource can serve the participant, the waiver agency must make an appropriate referral.

3. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

4. Excluded are those adaptations or improvements to the home that:

    a. Are of general utility;
    b. Are considered to be standard housing obligations of the participant or homeowner; and
    c. Are not of direct medical or remedial benefit to the participant.
    d. Examples of exclusions include, but are not limited to, carpeting, roof repair, sidewalks, driveways, heating, central air conditioning (unless minimum standard #4 as described above is met), garages, raised garage doors, storage and organizers, hot tubs, whirlpool tubs, swimming pools, landscaping and general home repairs.

5. Environmental adaptations must exclude costs for improvements exclusively required to meet local building codes.

6. 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.

7. 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.

8. The existing structure must have the capability to accept and support the proposed changes.

9. The MI Choice waiver 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 assure the home will meet basic needs, such as having a ground floor bath or bedroom if the participant has mobility limitations. However, MI Choice waiver 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.

10. If modifications are needed to a home under construction that require special adaptation to the plan (e.g. roll-in shower), the MI Choice waiver may be used to fund the difference between the standard fixture and the modification required to accommodate the participant's need.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Minimum Operating Standards for MI Choice Waiver Program Services

NAME	Fiscal Intermediary Services
DEFINITION	Fiscal Intermediary services assist participants in self-determination in acquiring and maintaining services defined in the participant's PCSP, controlling a participant's budget, and choosing staff authorized by the waiver agency. The fiscal intermediary helps a participant manage and distribute funds contained in an individual budget. Funds are used to purchase waiver goods and services authorized in the participant's PCSP. Fiscal Intermediary services include, but are not limited to, the facilitation of the employment of MI Choice service providers by the participant (including federal, state, and local tax withholding or payments, unemployment compensation fees, wage settlements), fiscal accounting, tracking and monitoring participant directed budget expenditures and identifying potential over- and under-expenditures, and assuring compliance with documentation requirements related to management of public funds. The fiscal intermediary may also perform other supportive functions that enable the participant to self-direct needed services and supports. These functions may include verification of provider qualifications, including reference and criminal history review checks, and assisting the participant to understand billing and documentation requirements.
HCPCS CODE	**T2025**, Waiver Services, not otherwise specified.
UNITS	As specified in the contract between the Fiscal Intermediary and the waiver agency, usually a monthly or bi-weekly fee.
SERVICE DELIVERY OPTIONS	☐ Traditional/Agency-Based ☑ Self-Determination

Minimum Standards for Self-Determined Service Delivery

1. Each Fiscal Intermediary (FI) agency must satisfactorily pass a readiness review conducted by a waiver agency, as specified in Attachment N of the MI Choice contract and meet all criteria sanctioned by the state.

2. Each FI must be bonded and insured. The insured amount must exceed the total budgetary amount the FI is responsible for administering.

3. 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.

4. Each FI must demonstrate competence in managing budgets and performing other functions and responsibilities of a fiscal intermediary.

5. Each FI will provide four basic areas of performance:

    a. Function as the employer agency for participants directly employing workers to assure compliance with payroll tax and insurance requirements;

b. 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;
c. 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
d. Offer supportive services to enable participants to self-determine and direct the services and supports they need.

6. The waiver agency and FI must abide by the principles set forth in the Self-Determination Technical Advisory "Choice Voucher System" available at:

   www.hcbs.org/moreInfo.php/doc/2928

7. 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 functions outlined in standard #5 above.

Limitations

1. Fiscal Intermediary services are only available to those participants choosing the self-determination option for service delivery.

2. Providers of other covered services to the participant, family, or guardians of the participant may not provide FI services to the participant.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Minimum Operating Standards for MI Choice Waiver Program Services

NAME	Goods and Services
DEFINITION	Goods and services are services, equipment, or supplies not otherwise available through the MI Choice waiver or the Medicaid State Plan that address an identified need in the individual PCSP, including improving and maintaining the participant's opportunities for full membership in the community.
HCPCS CODE	**T2041**, Supports brokerage, self-directed, waiver per 15 minutes **T5999**, Supply, not otherwise specified.
UNITS	T2041 = per 15 minutes T5999 = one unit per item
SERVICE DELIVERY OPTIONS	☐ Traditional/Agency-Based ☑ Self-Determination

Minimum Standards for Self-Determined Service Delivery

1. Each chosen provider must minimally comply with Section C of the "General Operating Standards for MI Choice Waiver Service Providers."

2. Waiver agencies may obtain some items directly from a retail store that offers the item to the general public (i.e. Wal-Mart, K-mart, Meijer, Costco, etc.). When utilizing retail stores, the waiver agency must assure 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.

3. Each item specified in the PCSP as Goods and Services must meet the following requirements:

   a. The item or service would decrease the need for other Medicaid services; or
   b. Promote inclusion in the community; or
   c. Increase the participant's safety in the home environment; and,
   d. The participant does not have the funds to purchase the item or service or the item or service is not available through another source.

4. The item or service must be designed to meet the participant's functional, medical, or social needs and advance the desired outcomes in the participant's individual PCSP.

5. Self-directed Goods and Services are purchased from the participant-directed budget.

6. 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.

Limitations

1. This service is only available to those participants choosing self-determination.

2. Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first.

3. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

4. This service excludes experimental or prohibited treatments.

5. Federal or State Medicaid or other statues and regulations, including the State's Procurement Requirement, may not prohibit the services or items authorized for purchase.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Minimum Operating Standards for MI Choice Waiver Program Services

NAME	**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 dietary reference intake (DRI) allowances for the age group as established by the Food and Nutritional Board of the Institute of Medicine of the National Academy of Sciences. Allowances must be made in HDMs for specialized or therapeutic diets as indicated in the participant's PCSP. Home Delivered Meals cannot constitute a full nutritional regimen.
HCPCS CODE	**S5170**, Home delivered meals, including preparation, per meal.
UNITS	One delivered meal
SERVICE DELIVERY OPTIONS	☑ Traditional/Agency-Based ☐ Self-Determination

Minimum Standards for Traditional Service Delivery

The standards identified below apply only to individuals for whom the MI Choice waiver program is purchasing home delivered or congregate meals. Waiver agencies authorize MI Choice payment of meals for qualified participants.

General Requirements

1. Each direct service provider must have written policies and procedures compatible with the "General Operating Standards for Waiver Agencies and Contracted Direct Service Providers," and minimally, Section A of the "General Operating Standards for MI Choice Waiver Providers."

2. All congregate meals providers must meet the MDHHS Aging and Adult Services Agency requirements for congregate meals providers and be an approved provider of congregate meals by the local Area Agency on Aging.

3. 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:

    a. The participant must be unable to consistently obtain food or prepare meals for themselves because of:
        i. A disabling condition, such as limited physical mobility, cognitive or psychological impairment, or sight impairment, **or**
        ii. A lack of knowledge or skill to select and prepare nourishing and well-balanced meals, **or**
        iii. A lack of means to obtain or prepare nourishing meals, **or**
        iv. A lack of incentive to prepare and eat a meal alone, **or**
        v. A lack of informal supports who are both willing and able to perform the services needed, **or**
        vi. A need to supplement the informal supports available with additional meals.
    b. The participant does not have a paid caregiver that is able and willing to prepare meals for the participant.

c. The provider can appropriately meet the participant's special dietary needs as defined by the most current version of the US Department of Agriculture "Dietary Guidelines for Healthy Americans".
d. The participant must be able to feed him or herself.
e. The participant must agree to be home when meals are delivered, or contact the program when absence is unavoidable.

4. Each provider must have written policies and procedures that integrates 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.

5. 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.

6. Each home delivered or congregate meals provider must have the capacity to provide three meals per day, which together meet the 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.

7. 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:

   a. Diet orders must include participant weight and specify the required nutritional content of the liquid meals.
   b. The supports coordinator must ensure the participant's physician renews the diet orders every three months, and
   c. The MI Choice RN supports coordinator and participant must develop the PCSP for participant receiving liquid meals in consultation with the participant's physician.

8. 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.

9. 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.

10. 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.

Nutrient Analysis Guidelines

1. 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.

2. Develop menu standards to sustain and improve a participant's health through the provision of safe and nutritious meals using specific guidelines.

3. Each meal served by the provider must meet the current U.S. Department of Agriculture/ Health and Human Services Dietary Guidelines 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.

4. The provider must offer meal components meeting the 33 1/3 percent of the DRI if the provider serves one meal per day. If the provider serves two meals per day, the provider must offer meal components meeting 66 2/3 percent of the DRI. If the provider serves three meals per day, the provider must offer meal components with 100 percent of the DRI.

5. Providers must design menu planning to:

    a. Include a variety of foods, especially fruits, vegetables, and whole grains;
    b. Increase the use of fresh or frozen fruits and vegetables, especially those high in potassium;
    c. Avoid too much total fat, saturated fat, trans fat, and cholesterol. Encourage mono- and polyunsaturated fats;
    d. Include foods with adequate complex carbohydrates and fiber;
    e. Avoid too much refined carbohydrates and added sugars;
    f. Encourage nutrient dense foods;
    g. Avoid too much sodium by using salt free herbs and spices, cooking from scratch, and using less processed and manufactured foods; and
    h. Provide an appropriate number of calories to help maintain ideal body weight.

6. 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.

7. Providers should track the nutrients in the chart below on a daily basis and may average them weekly. The target value represents 1/3 of the DRI for a >70 year old male, and is the minimum amount. Compliance range represents acceptable minimum and maximum values as specified by the State to allow flexibility and participant satisfaction. Use fortified foods to meet Vitamin B12 needs.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Minimum Operating Standards for MI Choice Waiver Program Services

Nutrient	Target Values (Minimum)	Compliance Values Averaged over one week
Calories	700	600-850
Protein	19 grams per meal	>=19 grams per meal
Total Fat Saturated Fat Trans Fat	<30% of calories <10% of calories No trans fat	<30% of calories No meal > 35% fat As low as possible
Fiber	10 grams	7 grams or higher
Calcium	400 mg	400 mg or higher
Magnesium (suggested food sources: bananas, raisins, legumes, nuts, whole grains, oatmeal, vegetables, milk, and milk products)	116 mg	116 mg or higher
Vitamin B6 (suggested food sources: fish, beef liver and other organ meats, potatoes and other starchy vegetables, fruit (excluding citrus), and fortified cereals)	0.6 mg	0.6 mg or higher
Vitamin B12 (suggested food sources: fish, red meat, poultry, eggs, milk and milk products, and fortified cereals)	0.8 mcg	0.8 mcg or higher
Vitamin C	30 mg	25 mg or higher
Sodium	800-1,200 mg	1,200 mg or less

8. These nutrients have been targeted for tracking because older adults frequently do not get enough of these nutrients, which affect bone and muscle health. Deficiencies can lead to balance problems and exacerbate existing chronic conditions.

9. Special Menus: To the extent practicable, adjust meals to meet any special dietary needs of the participants for health reasons, ethnic and religious preference, and to provide flexibility in designing meals that are appealing to participants.

10. Providers must be able to produce a nutrient analysis for a meal when requested by MDHHS, the waiver agency, a participant, a participant's family, or a medical provider. The provider does not have to list nutrient analysis on the menu.

Meal Planning Guidelines

1. The provider may serve vegetarian meals as part of the menu cycle or as an optional menu choice. Vegetarian meals must include a variety of flavors, textures, seasonings, colors, and food groups in the same meal.

2. Breakfast meals may include any combination of foods that meet the meal planning guidelines.

3. Providers may present hot, cold, frozen, or shelf-stable meals as long as the meals conform to the meal planning guidelines.

4. Each meal should include the following food groups: bread or bread alternative, vegetables, fruit, dairy, and meat or meat alternatives. The provider should refer to http://www.choosemyplate.gov for serving sizes of each meal component.

a. **Bread or Bread Alternatives** may include, but is not limited to:

Muffin	Cornbread	Biscuit	Waffle	French toast
English muffin	Tortilla	Pancakes	Bagel	Crackers
Granola	Graham Cracker	Dressing	Stuffing	Pasta
Sandwich bun	Cooked cereal	Bread, all types		

A variety of enriched or whole grain bread products, particularly those high in fiber, are recommended.

b. **Vegetables** include traditional vegetables and dried beans, peas, lentils, 100% vegetable juice, raw leafy vegetables, and other beans.

c. **Fruits** include traditional fruits; chopped, cooked, or canned fruit; 100% fruit juice; fresh, frozen, freeze-dried, juice, or canned fruit.

d. **Milk or Milk Alternatives** include traditional milk products and may include, but is not limited to:

Buttermilk	Low-fat chocolate milk	Lactose-free milk
Powdered milk	Evaporated milk	Yogurt
Cottage cheese	Tofu	Calcium fortified soy, rice, or almond milk
Natural or processed cheese		

e. **Meat or Meat Alternatives** include traditional meat products and may include, but is not limited to:

Eggs	Nuts	Cheese	Cottage Cheese	Dried beans
Dried lentils	Tofu	Nut butter	Tempeh	

A meat or meat alternative may be served in combination with other high protein foods. Avoid serving dried beans, nut butter, nuts, or tofu for consecutive meals or on consecutive days, except to meet cultural or religious preferences or for emergency meals.

Imitation cheese is made from vegetable oil, not from milk or milk products, and may not be served as a meat alternative.

Consider serving cured and processed meats (ham, smoked or Polish sausage, corned beef, dried beef) no more than once per week to limit sodium content of the meals.

f. **Accompaniments**
Include traditional meal accompaniments as appropriate, e.g., condiments, spreads, and garnishes. Examples include mustard or mayonnaise with a meat sandwich; tartar sauce with fish; salad dressing with tossed salad; margarine with bread or rolls. Whenever feasible, provide fat alternatives. Minimize use of fat in food preparation. Fats should be primarily from vegetable sources and in a liquid or soft (spreadable) form that are lower in hydrogenated fat, saturated fat, trans fats, and cholesterol.

g. **Desserts**
Serving a dessert is encouraged, but optional. Dessert suggestions include, but are not limited to fruit, fruit crisps with whole grain toppings, pudding with double milk, gelatin with fruit, low-fat frozen yogurt, and Italian ices. Limit the use of baked, commercial desserts to once per week.

h. **Beverages**
Fluid intake should be encouraged, as dehydration is a common problem in older adults. It is a good practice to have drinking water available.

Limitations

1. Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first.

2. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

3. The meals authorized under this service must not constitute a full nutritional regimen.

4. Providers must not solicit donations from waiver participants.

5. Providers must not use waiver funds to purchase dietary supplements such as vitamins and minerals.

6. 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.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Minimum Operating Standards for MI Choice Waiver Program Services

NAME	Non-Emergency Medical Transportation (NEMT)
DEFINITION	NEMT is defined in 42 CFR 431.53 and 42 CFR 440.170 and includes expenses for transportation and other related travel expenses determined necessary to secure medical examinations, documentation, or treatment for a MI Choice participant. Waiver agencies will ensure MI Choice participants have access to NEMT 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 NEMT. Additionally, delivery services for medical items, such as medical supplies or prescriptions, should be utilized before authorizing NEMT through the MI Choice program. NEMT includes, but is 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 Veteran Affairs hospital. Travel expenses related to the provision of NEMT 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, and • The attendant's salary, if the attendant is not a volunteer or a member of the MI Choice participant's family.
HCPCS CODES	**See List in Limitations section below**
UNITS	1 Mile; A0080, A0090, A0160, S0209, S0215 1 Leg of a trip; A0100, A0120, A0130, A0140, T2001, T2003, T2004, T2005 1 Meal; A0190, A0210 1 Overnight stay; A0180, A0200 ½ Hour; T2007 1 Day; A0110
SERVICE DELIVERY OPTIONS	☑ Traditional/Agency-Based ☑ Self-Determination

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Minimum Operating Standards for MI Choice Waiver Program Services

Minimum Standards for Traditional Service Delivery

1. Each direct service provider must have written policies and procedures compatible with the "General Operating Standards for Waiver Agencies and Contracted Direct Service Providers," and minimally, Section B of the "General Operating Standards for MI Choice Waiver Providers."

2. Waiver agencies may authorize NEMT as a MI Choice service for waiver participants. However, when possible, the waiver agency must utilize family, neighbors, friends, or community agencies that can provide this service without charge.

3. When authorizing NEMT waiver agencies are to authorize the least expensive available means suitable to the participant's needs.

4. Waiver agencies may only authorize NEMT to provide transportation assistance to the participant. The participant must travel away from home to other locations within the community. NEMT does not include reimbursement for caregivers of the participant to run errands or otherwise travel on behalf of the participant.

5. The Secretary of State must appropriately license all drivers and vehicles used for NEMT. The provider must cover all vehicles used with insurance as required by law.

6. Each provider must operate in compliance with P.A. 1 of 1985 regarding seat belt usage.

7. Waiver agencies may utilize a process to prior authorize requests for the following:

    a. All outstate travel that is non-borderland
    b. Overnight stays if within 50 miles one-way from the participant's home.
    c. Overnight stays beyond five nights, including meals and lodging.
    d. An attendant in addition to the driver of a wheelchair lift/medivan vehicle.
    e. Mileage and meal expenses for daily long-distance trips.

8. Waiver agencies must use the "SC" modifier on all encounter claims for NEMT to distinguish this service from Non-Medical Transportation, also available through MI Choice.

Minimum Standards for Self-Determined Service Delivery

1. Each chosen provider must minimally comply standards 2-8 of the Minimum Standards for Traditional Service Delivery specified above.

2. Volunteer drivers do not need to comply with standard 6 of the Minimum Standards for Traditional Service Delivery specified above. Volunteer drivers are those drivers who only seek reimbursement for mileage when furnishing NEMT.

Limitations

1. Where applicable, the participant must use other available payers or non-cost transportation first.

2. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

3. Waiver agencies must not authorize MI Choice funds 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 NEMT service is to enable MI Choice participants to gain access to medical services.

4. Reimbursement for NEMT **DOES NOT** include the following:

    a. Transportation for services not covered by Medicaid.
    b. Waiting time (waiting time may be built into the reimbursement rate)
    c. Transportation for medical services that have already been provided
    d. 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.

5. The following HCPCS codes are approved for use under the NEMT service definition:
    a. A0080, Non-emergency transportation, per mile - vehicle provided by volunteer (individual or organization), with no vested interest
    b. A0090, Non-emergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest
    c. A0100, Non-emergency transportation; taxi
    d. A0110, Non-emergency transportation and bus, intra- or inter- state carrier
    e. A0120, Non-emergency transportation: mini-bus, mountain area transports, or other transportation systems
    f. A0130, Non-emergency transportation: wheelchair van
    g. A0140, Non-emergency transportation and air travel (private or commercial) intra or inter state
    h. A0160, Non-emergency transportation: per mile - case worker or social worker
    i. A0170, Transportation ancillary: parking fees, tolls, other
    j. A0180, Non-emergency transportation: ancillary: lodging-recipient
    k. A0190, Non-emergency transportation: ancillary: meals-recipient
    l. A0200, Non-emergency transportation: ancillary: lodging escort
    m. A0210, Non-emergency transportation: ancillary: meals-escort
    n. S0209, Wheelchair van, mileage, per mile
    o. S0215, Non-emergency transportation; mileage, per mile
    p. T2001, Non-emergency transportation; patient attendant/escort
    q. T2002, Non-emergency transportation; per diem
    r. T2003, Non-emergency transportation; encounter/trip
    s. T2004, Non-emergency transport; commercial carrier, multi-pass
    t. T2005, Non-emergency transportation; stretcher van
    u. T2007, Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Minimum Operating Standards for MI Choice Waiver Program Services

NAME	Non-Medical Transportation
DEFINITION	Services offered to enable waiver participants to gain access to waiver and other community services, activities and resources, specified by the individual PCSP. Whenever possible, family, neighbors, friends, or community agencies that can provide transportation services without charge must be utilized before MI Choice provides transportation services. Non-Medical Transportation services offered through MI Choice are in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State Plan, defined at 42 CFR 440.170(a). Refer to the Non-Emergency Medical Transportation service standard for information on how to authorize medical transportation. 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 Non-Medical Transportation services.
HCPCS CODES	**A0130**, Non-Emergency Transportation; Wheelchair van; per trip **S0209**, Wheelchair van, mileage, per mile **S0215**, Non-Emergency Transportation, mileage, per mile **T2003**, Non-Emergency Transportation; encounter/trip **T2004**, Non-Emergency Transportation; commercial carrier, multi-pass
UNITS	A0130 = per leg of a trip S0209 = per mile S0215 = per mile T2003 = per encounter or trip T2004 = per pass
SERVICE DELIVERY OPTIONS	☑ Traditional/Agency-Based ☑ Self-Determination

Minimum Standards for Traditional Service Delivery

1. Each direct service provider must have written policies and procedures compatible with the "General Operating Standards for Waiver Agencies and Contracted Direct Service Providers," and minimally, Section B of the "General Operating Standards for MI Choice Waiver Providers."

2. Waiver agencies may authorize non-medical transportation as a MI Choice service for waiver participants. However, when possible, the waiver agency must utilize family, neighbors, friends, or community agencies that can provide this service without charge.

3. Waiver agencies may only authorize non-medical transportation to provide transportation assistance to the participant. The participant must travel away from home to other locations within the community. Non-medical transportation does not include reimbursement for caregivers of the participant to run errands or otherwise travel on behalf of the participant.

4. Direct service providers must be a centrally organized transportation company or agency. The provider may furnish transportation utilizing any of the following methods:

a. Demand/Response: Characterized by scheduling of small vehicles to provide door-to-door or curb-to-curb service on demand. The provider may include a passenger assistance component and either or both of the following variations:

   i. Route Deviation Variation: A normally fixed-route vehicle leaves the scheduled route upon request to pick up the participant.

   ii. Flexible Routing Variation: Providers constantly modify routes to accommodate service requests.

b. Public Transit: Characterized by partial or full payment of the cost for a participant to use an available public transit system. (This can be either a fixed route or demand/response). The provider may include a passenger assistance component.

c. Volunteer: Characterized by reimbursement of out-of-pocket expenses for individuals transporting participants in private vehicles. The provider may include a passenger assistance component.

d. Ambu-cab: Characterized by a wheelchair-equipped van to provide door-to-door service on demand. The provider must include a passenger assistance component.

5. The Secretary of State must appropriately license and inspect all drivers and vehicles used for transportation supported all or in part by MI Choice funds. The provider must cover all vehicles used with liability insurance.

6. 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.

7. 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.

8. Each provider must operate in compliance with P.A. 1 of 1985 regarding seat belt usage.

9. Each waiver agency and provider must attempt to receive reimbursement from other funding sources, as appropriate and available before utilizing MI Choice funds for transportation services. Examples include the American Cancer Society, Veterans Administration, MDHHS Field Offices, MDHHS Medical Services Administration, United Way, Department of Transportation programs, etc.

Minimum Standards for Self-Determined Service Delivery

1. Each chosen provider must minimally comply with Section C of the “General Operating Standards for MI Choice Waiver Service Providers”, and standards 1-3 of the Minimum Standards for Traditional Service Delivery specified above.

2. The Secretary of State must appropriately license and inspect all drivers and vehicles used for transportation supported all or in part by MI Choice funds. The provider must cover all vehicles used with no fault automobile insurance.

3. Each chosen provider for transportation services 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.

4. Each chosen provider must operate in compliance with P.A. 1 of 1985 regarding seat belt usage.

Limitations

1. Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first.

2. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

3. Waiver agencies may not use MI Choice funds to purchase or lease vehicles for providing transportation services to waiver participants.

4. Waiver agencies must not authorize MI Choice funds 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 transportation service is to enable MI Choice participants to gain access to waiver and other community services, activities and resources.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Minimum Operating Standards for MI Choice Waiver Program Services

NAME	Nursing Services
DEFINITION	MI Choice Nursing Services are covered on an intermittent (separated intervals of time) basis for a participant who requires nursing services for the management of a chronic illness or physical disorder in the participant's home and are provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the direct supervision of a registered nurse (RN). MI Choice Nursing Services are for participants who require more periodic or intermittent nursing than available through the Medicaid State Plan or other payer resources for the purpose of preventive interventions to reduce the occurrence of adverse outcomes for the participant such as hospitalizations and nursing facility admissions. MI Choice Nursing Services must not duplicate services available through the Medicaid State Plan or third payer resources.
HCPCS CODE	**T1002**, RN Services, up to 15 minutes **T1003**, LPN/LVN services, up to 15 minutes
UNITS	15 minutes
SERVICE DELIVERY OPTIONS	☑ Traditional/Agency-Based ☑ Self-Determination

Minimum Standards for Traditional Service Delivery

1. Each direct service provider must have written policies and procedures compatible with the "General Operating Standards for Waiver Agencies and Contracted Direct Service Providers", and minimally, Section A of the "General Operating Standards for MI Choice Waiver Providers."

2. When the participant's condition is unstable, could easily deteriorate, or when significant changes occur, 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 care professional to prevent additional decline, illness, or injury to the participant.

3. The supports coordinator must communicate with both the nurse providing this service and the participant's health care professional to assure the nursing needs of the participant are being addressed.

4. Participants must meet at least one of the following criteria to qualify for this service:

   a. Be at high risk of developing skin ulcers, or have a history of resolved skin ulcers that could easily redevelop.

   b. Require professional monitoring of vital signs when changes may indicate the need for modifications to the medication regimen.

   c. Require professional monitoring or oversight of blood sugar levels, including participant-recorded blood sugar levels, to assist with effective pre-diabetes or diabetes management.

d. 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.

e. Require professional evaluation of the participant's success with a prescribed exercise routine to assure its effectiveness and identify the need for additional instruction or modifications when necessary.

f. Require professional evaluation of the participant's physical status to encourage optimal functioning and discourage adverse outcomes.

g. 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 health care professional.

5. 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:

   a. Administering prescribed medications that the participant cannot self-administer (as defined under Michigan Complied Law (MCL) 333.7103(1)).

   b. Setting up medications according to physician orders.

   c. Monitoring participant adherence to their medication regimen.

   d. Applying dressings that require prescribed medications and aseptic techniques.

   e. Providing refresher training to the participant or informal caregivers to assure 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 activities of daily living, or safe ambulation within the home.

Minimum Standards for Self-Determined Service Delivery

1. Each chosen provider must minimally comply with Section C of the "General Operating Standards for MI Choice Waiver Service Providers."

2. When authorizing Nursing Services for participants choosing the self-determination option, waiver agencies must comply with items 2, 3, 4, and 5, of the Minimum Standards for Traditional Service Delivery specified above.

Limitations

1. Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first.

2. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

3. 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).

4. Participants receiving Private Duty Nursing services are not eligible to receive MI Choice Nursing Services.

5. All providers furnishing this service must be licensed as either a Registered Nurse or a Licensed Practical Nurse in the State of Michigan.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Minimum Operating Standards for MI Choice Waiver Program Services

NAME	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. This service also includes installation, upkeep, and maintenance of devices.
HCPCS CODES	**S5160**, Emergency response system; installation and testing **S5161**, Emergency response system; service fee, per month (excludes installation and testing)
UNITS	S5160, per installation S5161, per month
SERVICE DELIVERY OPTIONS	☑ Traditional/Agency-Based ☐ Self-Determination

Minimum Standards for Traditional Service Delivery

1. Each direct service provider must have written policies and procedures compatible with the "General Operating Standards for Waiver Agencies and Contracted Direct Service Providers," and minimally, Section A of the "General Operating Standards for MI Choice Waiver Providers."

2. 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.

3. 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.

4. The provider must staff the response center with trained personnel 24 hours per day, 365 days per year. The response center will provide accommodations for persons with limited English proficiency.

5. The response center must maintain the monitoring capacity to respond to all incoming emergency signals.

6. 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.

7. The provider will furnish each responder with written instructions and provide training, as appropriate.

8. The provider will verify the responder and contact names for each participant on a semi-annual basis to assure current and continued participation.

9. The provider will assure at least monthly testing of each PERS unit to assure continued functioning.

10. 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.

11. The provider will maintain individual client records that include the following:

    a. Service order,
    b. Record of service delivery, including documentation of delivery and installation of equipment, participant/caregiver orientation, and monthly testing,
    c. List of emergency responders for each participant, and
    d. A case log documenting participant and responder contacts.

Limitations

1. Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first.

2. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

3. PERS does not cover monthly telephone charges associated with phone service.

4. 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.

5. Waiver agencies may authorize PERS units for persons who do not live alone if both the waiver participant and the person with whom they reside would require extensive routine supervision without a PERS unit in the home. For example, if one or both spouses are waiver participants and both are frail and elderly, the waiver agency may authorize a PERS unit for the waiver participant(s). Supports coordinators must clearly document in the case record the reason for the provision of a PERS unit when the participant does not live alone or is not left alone for significant lengths of time.

6. Waiver agencies may provide a purchased unit similar to 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.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Minimum Operating Standards for MI Choice Waiver Program Services

NAME	Private Duty Nursing
DEFINITION	Private Duty Nursing (PDN) services are skilled nursing interventions provided to a participant age 21 and older on an individual and continuous basis to meet health needs directly related to the participant's physical disorder. PDN includes the provision of nursing 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 PCSP. To be eligible for PDN services, the waiver agency must find the participant meets either Medical Criteria I or Medical Criteria II, and Medical Criteria III. Regardless of whether the participant meets Medical Criteria I or II, the participant must also meet Medical Criteria III. The participant's PCSP must provide reasonable assurance of participant safety. This includes a strategy for effective back-up in the event of an absence of providers. The back-up strategy must include informal supports or the participant's capacity to manage his or her care and summon assistance. PDN for a participant between the ages of 18-21 is covered under the Medicaid State Plan.
HCPCS CODE	**T1000**, Private duty/independent nursing service(s); Licensed, up to 15 minutes.* *Use TD modifier to indicate an RN, and TE modifier to indicate an LPN
UNITS	Up to 15 minutes
SERVICE DELIVERY OPTIONS	☑ Traditional/Agency-Based ☑ Self-Determination

Medical Criteria

Medical Criteria I – The participant is dependent daily on technology-based medical equipment to sustain life. "Dependent daily on technology-based medical equipment" means:

1. Mechanical rate-dependent ventilation (four or more hours per day), or assisted rate-dependent respiration (e.g., some models of Bi-PAP); or

2. Deep oral (past the tonsils) or tracheostomy suctioning eight or more times in a 24-hour period; or

3. Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; or

4. Total parenteral nutrition delivered via a central line, associated with complex medical problems or medical fragility; or

5. Continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter and a documented need for skilled nursing assessment, judgment, and intervention in the rate of oxygen administration. This requirement 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 PO2 level is 55 mm HG or below.

Medical Criteria II – Frequent episodes of medical instability within the past three to six months, requiring skilled nursing assessments, judgments, or interventions (as described in III below) as a result of a substantiated medical condition directly related to the physical disorder.

Definitions:

1. "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.

2. "Medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder.

3. "Emergency medical treatment" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition.

4. "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 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.

5. "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 3 or more activities of daily living.

6. "Substantiated" means documented in the clinical or medical record, including the nursing notes.

Medical Criteria III – The participant requires continuous skilled nursing care on a daily basis during the time when a licensed nurse is paid to provide services.

Definitions:

1. "Continuous" means at least once every 3 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 nursing services.

2. "Skilled nursing" means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse. Skilled nursing care includes, but is not limited to:

    a. 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;

b. Managing mechanical rate-dependent ventilation or assisted rate-dependent respiration (e.g., some models of Bi-PAP) that is required by the beneficiary four or more hours per day;

c. Deep oral (past the tonsils) or tracheostomy suctioning;

d. Injections when there is a regular or predicted schedule, or injections that are required as the situation demands (prn), but at least once per month (insulin administration is not considered a skilled nursing intervention);

e. Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility;

f. Total parenteral nutrition delivered via a central line and care of the central line;

g. 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 nursing 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 PO2 level is 55 mm HG or below;

h. 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.

Minimum Standards for Traditional Service Delivery

1. All nurses providing private duty nursing to MI Choice participants must meet licensure requirements and practice the standards found under MCL 333.17201-17242, and maintain a current State of Michigan nursing license.

2. Each direct service provider must have written policies and procedures compatible with the “General Operating Standards for Waiver Agencies and Contracted Direct Service Providers,” and minimally, Section A of the “General Operating Standards for MI Choice Waiver Providers.”

3. Through a person-centered planning process, the waiver agency must determine the length and duration of services provided.

4. 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.

5. 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.

6. This service may include medication administration as defined under MCL 333.7103(1).

7. The waiver agency is responsible for assuring there is a physician order for the private duty nursing services authorized. The physician may issue this order directly to the provider furnishing PDN services. However, the waiver agency is responsible for assuring the PDN provider has a copy of these orders and delivers PDN services according to the orders.

8. The waiver agency must maintain a copy of the physician orders in the case record.

Minimum Standards for Self-Determined Service Delivery

1. Each chosen provider must minimally comply with Section C of the "General Operating Standards for MI Choice Waiver Service Providers."

2. When authorizing Private Duty Nursing for participants choosing the self-determination option, waiver agencies must comply with items 1, 3, 4, 5, 6, 7, and 8 of the Minimum Standards for Traditional Service Delivery specified above.

Limitations

1. Participants receiving MI Choice Nursing Services are not eligible to receive Private Duty Nursing Services.

2. All PDN services authorized must be medically necessary as indicated through the MI Choice assessment and meet the medical criteria described above.

3. The participant's physician, physician's assistant, or nurse practitioner must order PDN services and work in conjunction with the waiver agency and provider agency to assure services are delivered according to that order.

4. Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first.

5. The waiver agency and direct service provider must explore and utilize all other sources of funding before using MI Choice funds for PDN services.

6. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

7. Services paid for with MI Choice funds must not duplicate nor replace services available through the Michigan Medicaid state plan. Waiver agencies and direct service providers can find state plan coverage online in the Medicaid Provider Manual at http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf.

8. PDN is limited to persons aged 21 or older. PDN is a Medicaid State Plan benefit for persons under the age of 21 who qualify for the service.

9. It is not the intent of the MI Choice program to provide PDN 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 be authorized for a participant. These circumstances must be clearly described in the participant's case record and approved by MDHHS.

10. 24/7 PDN services cannot be authorized for persons who cannot direct their own services and supports, make informed decisions for themselves, or engage their emergency back-up plan without assistance. These persons must have informal caregivers actively involved in providing some level of direct services to the participant on a routine basis.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Minimum Operating Standards for MI Choice Waiver Program Services

NAME	**Respite (*provided at the participant's home or in the home of another*)**
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 individuals normally providing services and supports for the participant. This standard addresses respite provided in the participant's home or in the home of another. Respite does not include the cost of room and board. Respite can only be provided in the home of another when the participant is using the self-determination option for service delivery.
HCPCS CODE	**S5150**, Unskilled respite care, not hospice, per 15 minutes **S5151**, Unskilled respite care, not hospice, per diem
UNITS	S5150 = 15 minutes S5151 = per diem
SERVICE DELIVERY OPTIONS	☑ Traditional/Agency-Based ☑ Self-Determination

Minimum Standards for Traditional Service Delivery

1. Each direct service provider must have written policies and procedures compatible with the "General Operating Standards for Waiver Agencies and Contracted Direct Service Providers," and minimally, Section A of the "General Operating Standards for MI Choice Waiver Providers."

2. Participants choosing this method of service delivery **may not** choose to have respite furnished in the home of another.

3. Each waiver agency must establish and follow written eligibility criteria for in-home respite that include, at a minimum:

    a. 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.

    b. Participants have difficulty performing or are unable to perform activities of daily living without assistance.

4. Respite services include:

    a. Attendant care (participant is not bed-bound) such as companionship, supervision, and/or assistance with toileting, eating, and ambulation.

    b. Basic care (participant may or may not be bed-bound) such as assistance with ADLs, a routine exercise regimen, and self-medication.

5. 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 coincides with the condition and needs of the participant.

6. 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.

7. 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 registered nurse and must include, at a minimum:

   a. 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.

   b. Verification of prescription medications and their dosages. The participant must maintain all medications in their original, labeled containers.

   c. Instructions for entering medication information in participant files.

   d. 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.

8. Each direct service provider must employ a professionally qualified supervisor that is available to staff during their shift while providing respite care.

9. 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.

10. Family members who provide respite services must meet the same standards as providers who are unrelated to the individual.

11. The waiver agency must not authorize respite services to relieve a caregiver that receives waiver funds to provide another service to the waiver participant. For example, if the waiver agency has authorized a niece to provide 30 hours per week of community living supports to the participant and pays for this service with waiver funds, the waiver agency must not also authorize additional hours of respite to relieve that niece of her caregiver duties. Rather, the waiver agency should decrease the niece's paid hours and authorize another caregiver to provide the needed services and support to the participant.

    This requirement may be waived if:

    a. 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. in the example above the participant has a medical need for 50 hours per week of services); **and**

b. The case record demonstrates the paid caregiver furnishes unpaid services and supports to the participant (i.e. the niece is paid for 30 hours per week, but actually delivers 50 hours per week of services); **and**

c. 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 niece regularly furnishes).

Minimum Standards for Self-Determined Service Delivery

1. Each chosen provider must minimally comply with Section C of the "General Operating Standards for MI Choice Waiver Service Providers."

2. Participants choosing this method of service delivery may choose to have respite services delivered in the home of another.

3. When authorizing Respite services for participants choosing the self-determination option, waiver agencies must comply with items 2, 3, 5, 8, 9, and 10 of the Minimum Standards for Traditional Service Delivery specified above.

Limitations

1. 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.

2. Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first.

3. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

4. The costs of room and board are not included.

5. 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.

6. Respite should be used on an intermittent basis to provide scheduled relief of informal caregivers.

7. The waiver agency must not authorize waiver funds to pay for respite services provided by the participant's usual caregiver.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Minimum Operating Standards for MI Choice Waiver Program Services

NAME	**Respite *(provided outside of the home)***
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 individuals normally providing services and supports for the participant. This standard addresses respite provided outside of the home. When provided in a Medicaid-certified hospital or a licensed Adult Foster Care facility, this type of respite may include the cost of room and board.
HCPCS CODE	**H0045**, Respite services not in the home, per diem
UNITS	H0045 = per day
SERVICE DELIVERY OPTIONS	☑ Traditional/Agency-Based ☐ Self-Determination

Minimum Standards for Traditional Service Delivery

1. Each direct service provider must have written policies and procedures compatible with the "General Operating Standards for Waiver Agencies and Contracted Direct Service Providers," and minimally, Section B of the "General Operating Standards for MI Choice Waiver Providers."

2. Out of home respite providers must also adhere to parts 5 and 6 of Section A of the "General Operating Standards for MI Choice Waiver Providers."

3. Each out of home respite service provider must be either a Medicaid certified hospital or a licensed group home as defined in MCL 400.701 ff, which includes adult foster care homes and homes for the aged. This does not include nursing facilities.

4. Each waiver agency must establish and follow written eligibility criteria for out-of-home respite that include, at a minimum:

    a. 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.

    b. Participants have difficulty performing or are unable to perform activities of daily living without assistance.

5. Respite services include:

    a. Attendant care (participant is not bed-bound) such as companionship, supervision and/or assistance with toileting, eating, and ambulation.

    b. Basic care (participant may or may not be bed-bound) such as assistance with ADLs, a routine exercise regimen, and self-medication.

6. The direct service provider must obtain a copy 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.

7. Each direct service provider must demonstrate a working relationship with a hospital and/or other health care facility for the provision of emergency health care services, as needed. 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.

8. Each direct service provider must establish written procedures to govern the assistance given by staff to participants with self-medications. These procedures must be reviewed by a consulting pharmacist, physician, or registered nurse and must include, at a minimum:

    a. The provider staff authorized to assist participants in taking either 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.

    b. Verification of prescription medications and their dosages. The participant must maintain all medications in their original, labeled containers.

    c. Instructions for entering medication information in participant files.

    d. A clear statement of the participant's and participant's family's responsibility regarding medications taken by the participant while at the facility and the provision for informing the participant and the participant's family of the program's procedures and responsibilities regarding assisted self-administration of medications.

9. Each direct service provider must employ a professionally qualified program director that directly supervises program staff.

Limitations

1. MDHHS does not intend Respite services to be furnished 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.

2. Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first.

3. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

4. For each participant, the waiver agency must not authorize MI Choice waiver payment for more than 30 days of out of home respite service per calendar year. Calendar years consist of any 365-day period.

5. 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, depending upon the needs of the participant and the participant's caregivers, such as when informal supports are on vacation.

6. Respite should be used on an intermittent basis to provide scheduled relief of informal caregivers.

7. The waiver agency must not authorize waiver funds to pay for respite services provided by the participant's usual caregiver.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Minimum Operating Standards for MI Choice Waiver Program Services

NAME	Specialized Medical Equipment and Supplies
DEFINITION	Specialized Medical Equipment and Supplies includes devices, controls, or appliances that enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support or to address physical conditions, along with ancillary supplies and equipment necessary to the proper functioning of such items. This service excludes those items that are not of direct medical or remedial benefit to the participant. Durable and non-durable medical equipment and medical supplies not available under the State Plan that are necessary to address the participant's functional limitations may be covered by this service. Medical equipment and supplies furnished under the State Plan must be procured and reimbursed through that mechanism and not through MI Choice. All items must be specified in the participant's PCSP. All items 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.
HCPCS CODES	Please see list included in item #10 under minimum standards.
UNITS	Per item, unless otherwise specified.
SERVICE DELIVERY OPTIONS	☑ Traditional/Agency-Based ☐ Self-Determination

Minimum Standards for Traditional Service Delivery

1. Each direct service provider must enroll in Medicare and/or Medicaid as a Durable Medical Equipment provider, pharmacy, etc., as appropriate.

2. Waiver agencies may obtain some items directly from a retail store that offers the item to the public (i.e. Wal-Mart, K-mart, Meijer, Costco, etc.). When utilizing retail stores, the waiver agency must assure 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.

3. Each direct service provider must have written policies and procedures compatible with the "General Operating Standards for Waiver Agencies and Contracted Direct Service Providers," and minimally, Section B of the "General Operating Standards for MI Choice Waiver Providers."

4. The waiver agency and/or direct service provider must pursue payment by Medicare, Medicaid state plan, or other entities, as applicable before the waiver agency authorizes MI Choice payment.

5. The waiver agency must document the medical or remedial benefit the equipment or supply provides to the participant in the participant's case record.

6. Where feasible, the waiver agency or direct service provider must seek affirmation of the need for the item provided from the participant's physician.

7. 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.

8. 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 home delivered meals 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.

9. The waiver agency must not authorize MI Choice payment for herbal remedies or other over-the-counter medications for uses not authorized by the FDA.

10. The following HCPCS codes are approved for use under the Specialized Medical Equipment and Supplies service:

    a. **A4931**, Oral Thermometer, Reusable, any type, each
    b. **A4932**, Rectal Thermometer, Reusable, any type, each
    c. **A9300**, Exercise Equipment
    d. **B4100**, Food thickener, administered orally, per ounce
    e. **B4150/BO**, Enteral Formulae; Category 1; Semi-synthetic Intact Protein/Protein isolates, administered thru an enteral feeding tube, 100 calories=1unit
        i. The waiver agency must use the BO modifier to indicate oral administration. The state plan covers formulae for tube feeding.
        ii. This product may be in any form, liquid, solid, powder, bar, etc.
        iii. For cans of nutritional supplement, one can equals one unit.
        iv. For bars of nutritional supplement, one bar equals one unit.
    f. **E0160**, Sitz type bath or equipment, portable, used with or without commode
    g. **E0161**, Sitz type bath or equipment, portable, used with or without commode, with faucet attachment
    h. **E0210**, Electric heat pad, standard
    i. **E0215**, Electric heat pad, moist
    j. **E0241**, Bathtub wall rail, each
    k. **E0242**, Bathtub rail, floor base
    l. **E0243**, Toilet rail, each
    m. **E0244**, Raised toilet seat
    n. **E0245**, Tub stool or bench
    o. **E0315**, Bed accessory; board, table, or support device, any type
    p. **E0627**, Seat lift mechanism incorporated into a combination lift chair mechanism
    q. **E0628**, Separate seat lift mechanism for use with patient owned furniture, electric
    r. **E0629**, Separate seat lift mechanism for use with patient owned furniture, non-electric

s. **E0745** Neuromuscular stimulator, electronic shock unit
t. **E1300** Whirlpool, portable (overtub type)
u. **E1310** Whirlpool, non-portable (built-in type)
v. **E1639**, Scale, each
w. **S5162**, Emergency response system; purchase only
x. **S5199**, Personal care item, NOS, each
    i. Use this code for items that the participant uses to perform ADLs or IADLs, or that assist the participant in the performance of ADLs or IADLs.
    ii. This category must exclude items such as shampoo, soap, toothpaste, toothbrushes, dent-tips, shaving cream, and razors.
    iii. The waiver agency must include a description of this item in the appropriate loop for approval of a claim.
    iv. Standardized remarks are available.
y. **T1999**, Misc. Therapeutic items & supplies, retail purchases, NOC, identify product in “remarks”
    i. Items in this category have a therapeutic use for the participant.
    ii. The waiver agency must include a description of this item in the appropriate loop for approval of a claim.
    iii. Standardized remarks are available.
z. **T2028**, Specialized supply, NOS, waiver
    i. Items in this category include specialized supplies that the Medicaid state plan does not cover.
    ii. This may include items that do not meet the “medically necessary” standard for state plan coverage, or quantities above state plan coverage.
    iii. The waiver agency must include a description of this item in the appropriate loop for approval of a claim.
    iv. Standardized remarks are available.
aa. **T2029**, Specialized medical equipment, NOS, waiver
    i. Items in this category include specialized equipment that the Medicaid state plan does not cover, or does not cover for adults.
    ii. This may include items that do not meet the “medically necessary” standard for state plan coverage.
    iii. The waiver agency must include a description of this item in the appropriate loop for approval of a claim.
    iv. Standardized remarks are available.
bb. **T2039**, Vehicle Modifications, waiver, per service
cc. **T4537**, Incontinence product, protective underpad, reusable, bed size, each
dd. **T4540**, Incontinence product, protective underpad, reusable, chair size, each
ee. **V5268**, Assistive listening device, telephone amplifier, any type
ff. **V5269**, Assistive listening device, alerting, any type
gg. **V5270**, Assistive listening device, television amplifier, any type

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Minimum Operating Standards for MI Choice Waiver Program Services

NAME	Supports Coordination
DEFINITION	Supports Coordination is provided to assure the provision of supports and services needed to meet the participant's health and welfare needs in a home and community-based setting. Without these supports and services, the participant would otherwise require institutionalization. The supports coordination functions to be performed and the frequency of face-to-face and other contacts are specified in the participant's PCSP. The frequency and scope of supports coordination contacts must take into consideration health and safety needs of the participant. Supports Coordination does not include the direct provision of other Medicaid services.
HCPCS CODE	**T2022**, Case management, per month
UNITS	One unit per month
SERVICE DELIVERY OPTIONS	☑ Traditional/Agency-Based ☐ Self-Determination

Minimum Standards for Traditional Service Delivery

1. Each direct service provider must have written policies and procedures compatible with the "General Operating Standards for Waiver Agencies and Contracted Direct Service Providers," and minimally, Section A of the "General Operating Standards for MI Choice Waiver Providers."

2. Each supports coordinator must have a valid Michigan license as a registered nurse or a licensed social worker and be trained and knowledgeable about the program requirements for MI Choice as well as other available community resources.

3. Functions performed by a supports coordinator include:

    a. Assure the participant meets the Nursing Facility Level of Care per MDHHS policy.

    b. Conduct the initial assessment and periodic reassessments.

    c. 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.

    d. Develop a PCSP, including revisions to the PCSP at the participant's initiation, or as changes in the participant's circumstances may warrant.

    e. 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.

    f. Monitor MI Choice waiver services and other services and supports necessary for achievement of the participant's goals. Monitoring includes providing opportunities for the participant to evaluate the quality of services received and indicate whether those services achieved desired

outcomes. This activity includes the participant and other key sources of information as determined by the participant.

g. Provide social and emotional support to the participant and allies to facilitate life adjustments and reinforce the participant's sources of support. This may include arranging services to meet those needs.

h. Provide advocacy to support the participant's access to benefits, assure the participant's rights as a program beneficiary, and support the participant's decisions.

i. Maintain documentation of the above listed activities to ensure successful support of the participant, comply with Medicaid and other relevant policies, and meet the performance requirements delineated in the waiver agency's contract with MDHHS.

4. Additional requirements and standards for performing the functions required of a supports coordinator are defined in the document "Supports Coordination Service Performance Standards and MI Choice Program Operating Criteria" which is Attachment K of the contract between the waiver agency and MDHHS.

Limitations

1. Participant must need and agree to accept at least one additional MI Choice service every 30 days to qualify for the program.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
Minimum Operating Standards for MI Choice Waiver Program Services

NAME	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 PCSP. Training is covered for areas such as activities of daily living, adjustment to home or community living, adjustment to mobility impairment, adjustment to serious impairment, management of personal care needs, the development of skills to deal with service providers and attendants, and effective use of adaptive equipment. For participants self-directing services, Training services may also include the training of independent supports brokers, developing and managing individual budgets, staff hiring, training, and supervision, or other areas related to self-direction.
HCPCS CODES	**S5110**, Home care training, family, per 15 minutes **S5115**, Home care training, non-family, per 15 minutes
UNITS	S5110 = 15 minutes S5115 = 15 minutes
SERVICE DELIVERY OPTIONS	☑ Traditional/Agency-Based ☐ Self-Determination

Minimum Standards for Traditional Service Delivery

1. Each direct service provider must have written policies and procedures compatible with the "General Operating Standards for Waiver Agencies and Contracted Direct Service Providers," and minimally, Section A of the "General Operating Standards for MI Choice Waiver Providers."

2. Direct service providers must possess credentials required by Michigan laws or federal regulations, including:

   a. MCL 333.17801…333.17831 (physical therapist),
   b. MCL 333.18301…333.18311 (occupational therapist),
   c. MCL 333.18501…333.18518 (social worker), and/or
   d. MCL 333.17201…333.17242 (nursing)

3. 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.

4. The waiver agency must maintain verification of training provided to self-determined workers in the participant's case record.

Limitations:

1. Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first.

2. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Minimum Operating Standards for MI Choice Waiver Program Services

DEFINITION OF TERMS

Acronym or Term	Definition
CHAMPS	Community Health Automated Medicaid Payment System, Michigan's MMIS, the software Michigan uses to process Medicaid claims and encounter data.
CLS	Community Living Supports
CTS	Community Transition Services
CMS	The Centers for Medicare and Medicaid Services, a division of the Federal Health and Human Services Department
Direct Service Provider	A business, agency, company or other entity under subcontract with a waiver agency to provide MI Choice services to participants. This term also includes individuals hired by MI Choice participants to deliver self-determined services.
FFP	Federal Financial Participation, the federal government's share of approved Medicaid expenses.
MI Choice	Michigan's home and community based services for the elderly and disabled Medicaid waiver program. This is a combination 1915b/c waiver.
MDHHS	The Michigan Department of Health and Human Services
MDHHS Field Office	Formerly the Department of Human Services, this section of MDHHS receives applications and authorizes assistance programs including Medicaid and SNAP.
MMIS	The Medicaid Management Information System, the software MDHHS uses to process claims for Medicaid reimbursement and encounter data.
NFT	Nursing Facility Transition, the services and supports offered to a nursing facility resident to transition that resident to the community, with or without the support of enrollment in the MI Choice program upon discharge from the facility.
PAHP	Pre-paid Ambulatory Health Plan, an agency that administers the MI Choice Waiver program for MDHHS.
Participant	A person enrolled in the MI Choice program.
PCP	Person-Centered Planning. A highly individualized process designed to respond to the expressed needs and desires of the individual.
Person-Centered Service Plan	An individualized, comprehensive document developed by participants and supports coordinators using a person-centered approach that identifies each participant's strengths, weaknesses, needs, goals, outcomes, and planned interventions. This document includes all services provided to or needed by the participant, regardless of funding source.
PSA	Provider Service Area
Waiver Agency	An entity, under contract with MDHHS to administer the MI Choice program in a specific PSA.