MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

MINIMUM OPERATING STANDARDS

FOR MI CHOICE WAIVER

PROGRAM SERVICES

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

October 1, 2013

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
Minimum Operating Standards for MI Choice Waiver Program 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 Community Health (MDCH).

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 MDCH. Service providers may only deliver MI Choice waiver services through a formal sub-contractual agreement between the waiver agency and the service provider agency. Each sub-contract must contain all applicable contract components required by MDCH.

B. Compliance with Service Definitions

State and/or Federal funds awarded by MDCH may only pay for those services that MDCH has included and defined in the Centers for Medicare and Medicaid Services (CMS)-approved waiver application and for which MDCH 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 shall utilize a person-centered planning process and knowledge of person-centered planning shall 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 shall implement person-centered planning in accordance with the MDCH 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 shall maintain all client information in controlled access files. This requirement applies to all protected information whether written, electronic, or oral.

F. Insurance Coverage

4. Each waiver agency and direct service provider shall have sufficient insurance to indemnify loss of federal, state, and local resources, due to casualty or fraud. Insurance coverage sufficient to reimburse MDCH or the waiver agency for the fair market value of the asset at the time of loss shall cover all buildings, equipment, supplies, and other property purchased in whole or in part with funds awarded by MDCH. 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)

5. MDCH 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

G. Volunteers

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

H. Staffing

Each waiver agency or direct service provider shall 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 shall demonstrate an organizational structure including established lines of authority. Each direct service provider shall 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. Maintenance of records and files (as appropriate);
3. Emergency procedures
4. Assessment and observation skills; and
5. 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 shall maintain records detailing dates of training and topics covered in employee personnel files.

Waiver agencies and/or direct service providers shall 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 shall 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

MDCH 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 six years.

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. Priority Classification System

   Each waiver agency shall establish and utilize written procedures to identify participant priority for receiving services according to the participant's needs in the event of an emergency. Waiver agencies shall make direct service providers aware of their written procedures for prioritizing services and the classification of each participant served by that provider within the prioritization framework so that the service provider can target services to the highest priority participants in emergencies.

2. Charging for MI Choice Services

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

3. Participant Assessments

   Each waiver agency shall complete the state-approved assessment instrument for each participant according to established standards before initiating service. Direct providers of home-based services shall avoid duplicating assessments of individual participants to the maximum extent possible. Home-based service providers shall accept assessments conducted by waiver agencies and initiate home-based services without having to conduct a separate assessment. Waiver agencies shall 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.

4. Plans of Service

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

The service plan must contain at a minimum:

a. The type of service(s) furnished
b. The amount of service
c. The frequency and duration of each service
d. The type of provider to furnish each service
e. Participant focused goals and outcomes
f. 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

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 per 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 authorization 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/or 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 six years.

7. Notifying Participant of Rights

Each waiver agency or direct provider of home-based services must notify each participant, in writing, at the time service is initiated 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, and/or in each employee's personnel file. The employer shall 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/or volunteer staff person who will be entering participant homes. The waiver agency and direct provider shall 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 MDCH 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 be able to adequately and appropriately communicate, both orally and in writing, with their employers and the MI Choice participants they serve. This includes the ability to properly follow product instructions 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. Service contractors and direct service workers will be promptly informed 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 out 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 medical, social, and/or functional participant information as necessary to 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 six years.

3. Notifying Participant of Rights

Each waiver agency or direct provider of home-based services must notify each participant, in writing, at the time service is initiated 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 Background 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/or volunteer staff person who will be entering participant homes. The waiver agency and direct provider shall 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, non-medical 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 home and community-based services direct care workers for designated self-determined services in the participant's plan of service. 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 plan of services. 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 shall 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 at least 18 years of age,
b. Be able to communicate effectively both orally and in writing and follow instructions, and
c. Be trained in universal precautions and blood-borne pathogens. The waiver agency must maintain a copy of the employee's training record in the participant's case file.
d. Providers of self-determined services cannot also be the participant's spouse, legal guardian, or designated representative.

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 providing 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 plan of service.

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
Minimum Operating Standards for MI Choice Waiver Program Services

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 plan of service, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Meals provided as part of these services shall not constitute a "full nutritional regimen," i.e., three meals per day. Physical, occupational and speech therapies may be furnished as component parts of this service. 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 shall 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 or be unable to perform without assistance, activities of daily living (ADL).

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 and/or postpone deterioration that would likely lead to institutionalization.

3. A referral from a waiver agency for a MI Choice participant shall replace any screening or assessment activities performed for other program participants. The direct adult day health service provider shall accept copies of the MI Choice assessment and service plan to eliminate duplicate assessment and service planning activities.

4. Each program shall 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. Assessment of individual need or copy of assessment (and reassessments from referring program.
d. Service plan (with notation of any revisions), or copy of MI Choice service plan.
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 any and all release of information about the participant.
j. Signed release of information form.

Each program shall keep all participant files confidential in controlled access files. Each program shall use a standard release of information form that is time limited and specific as to the released information.

5. Each program shall 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 shall be in place. For MI Choice participants, the waiver agency shall 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 in attendance from eight to fourteen hours per day shall 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 shall 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, to maintain or restore abilities and skill, to prevent deterioration, and to 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 shall be in place.

   a. Rehabilitative: Physical, occupational, speech, and hearing therapies provided under order from a physician by licensed practitioners.
   b. Medical Support: Laboratory, X-ray, or pharmaceutical services provided under order from a physician by licensed professionals.
   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 shall 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 regiment, 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 shall 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 shall 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 shall maintain a written agreement that clearly specifies the terms of the arrangement between the provider and other individual or organization.

9. The provider shall 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 shall have basic first-aid training.

10. The provider shall require staff to attend in-service training at least twice each year. The provider shall 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 shall 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 shall meet the following transportation minimum standards:

    a. The Secretary of State shall appropriately license all drivers and vehicles and all vehicles shall be appropriately insured.
    b. All paid drivers shall be physically capable and willing to assist persons requiring help to get in and out of vehicles. The provider shall make such assistance available unless expressly prohibited by either a labor contract or an insurance policy.
    c. All paid drivers shall be trained to cope with medical emergencies unless expressly prohibited by a labor contract.
    d. Each program shall operate in compliance with P.A. 1 of 1985 regarding seat belt usage.

12. Each provider shall have first-aid supplies available at the program site. The provider shall 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 shall post procedures to follow in emergencies (fire, severe weather, etc.) in each room of the program site. Providers shall conduct practice drills of emergency procedures once every six months. The program shall maintain a record of all practice drills.

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

    a. At least one straight back or sturdy folding chair for each participant and staff person.
    b. Lounge chairs and/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 shall maintain all equipment and furnishings used during program activities or by program participants in safe and functional condition.

15. Each day care center shall 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:

6. 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.
7. Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first.
8. The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.
9. HCPCS codes S5101 and S5102 are limited to one unit per day.

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
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, tacking down loose rugs and tiles, and moving heavy items of furniture in order to provide safe access and egress. Other covered services might include yard maintenance (mowing, raking and clearing hazardous debris such as fallen branches and trees) and snow plowing to provide safe access and egress outside the home. These types of services are allowed only in cases when neither the participant nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community or volunteer agency, or third party payer is capable of, or responsible for, their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.
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 plan of service.

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

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 COMMUNITY HEALTH
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 shall not also be authorized as a separate waiver service for the beneficiary. Transportation to medical appointments is covered by Medicaid through the Department of Human Services (DHS).
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/or 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/or 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 (excluding to and from medical appointments) 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/or monitoring of medication administration

d. Staff assistance with preserving the health and safety of the individual in order that he/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, using libraries, or volunteer work.

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/or 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 shall 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. MDCH 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 provider must cover all vehicles used with liability insurance.

   c. All paid drivers for transportation providers supported entirely or in part by MI Choice funds shall be physically capable and willing to assist persons requiring help to and from and to get in and out of vehicles. The provider shall offer such assistance unless expressly prohibited by either a labor contract or insurance policy.

   d. The provider shall 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 shall 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 of age, 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 shall 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 and/or provider agency must train each worker to properly perform each task required for each participant the worker serves before delivering the service to that participant. The supervisor must assure that each worker can competently and confidently perform 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, shall establish written procedures that govern the

assistance given by staff to participants with self-medication. These procedures shall be reviewed by a consulting pharmacist, physician, or RN and shall 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 shall 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 shall 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 shall assure that medication use conforms to federal standards and the standards of the medical community.

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

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

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

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

g. A provider shall ensure that medication errors and adverse drug reactions are immediately and properly reported to a physician and recorded in the recipient'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 shall not replace usual and customary care 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 plan of service 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 RS, but shall not replace usual and customary homemaking tasks required by licensure.

Minimum Standards for Self-Determined Service Delivery

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/or 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 shall not also authorize transportation as a separate waiver service for the participant. The Medicaid state plan covers transportation to medical appointments through the Department of Human Services and waiver agencies shall not authorize the same as a component of CLS.

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 COMMUNITY HEALTH
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 MDCH 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. 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. Transition agencies must make the following assurances to MDCH:

   a. Transition agencies shall utilize a person-centered planning process and knowledge of person-centered planning shall 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 shall implement person-centered planning in accordance with the MDCH 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 shall maintain all participant information in controlled access files. This requirement applies to all protected information whether written, electronic, or oral.

c. Each transition agency utilizing volunteers shall have a written procedure governing the recruiting, training, and supervising of volunteers. Volunteers shall 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 shall accurately reflect dates of service provision.

5. The document “Nursing Facility Transition Exception and Billing Process” provides additional clarification regarding how to bill for CTS and is included as Attachment L of the MI Choice contract. Transition agencies shall refer to that document for instructions regarding specific items covered as CTS.

6. The transition agency shall 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 shall be one and the cost per unit shall equal the total cost.

7. The transition agency shall 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 shall equal no more than one per day, regardless of the number of assessments completed. The cost shall equal the total cost of all assessments, up to the approved amount as specified in Attachment L.

9. The transition agency shall 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 shall contact its contract manager for assistance. Waiver agencies shall 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 shall immediately contact the appropriate waiver agency. The waiver agency will conduct an assessment of 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 shall perform all transition activity for a nursing facility resident expected to enroll in MI Choice upon transition.**

11. When the transition agency does not anticipate that a nursing facility resident receiving CTS will require MI Choice services in the community, the transition agency must notify MDCH for prior approval of transition services funding.

12. 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 and must minimally include the following elements:

    a. Nursing facility resident name.
    b. Nursing facility resident identifying information including Social Security Number and Medicaid Recipient ID number.
    c. Name and address of nursing facility in which the resident resides.
    d. Date of initial contact.
    e. Estimated date of transition to MI Choice and/or community.
    f. Needed or anticipated NFT services.
    g. Participant goals and expected outcomes of community transition.

13. The transition agency must notify MDCH 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.

14. All transition agencies must notify MDCH 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.

15. 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 shall contact the preferred community PSA transition agency. Each transition agency shall 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.

16. When a NFT participant requires a home modification (also known as an environmental accessibility adaptation), the modification shall conform to the MI Choice Environmental Accessibility Adaptation service standards.

17. 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 MDCH 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 shall authorize only those modifications immediately necessary for community transition as CTS. The waiver agency shall authorize all other needed modifications as Environmental Accessibility Adaptation services or Chore services, as appropriate.

5. The transition agency shall 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 shall contact its contract manager and request an extension of the transition period.

6. Within 15 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. Items identified after this date will need to be discussed with MDCH and justified as a transition expense.

7. Transition agencies shall 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 of this time frame if the NFT participant has unique circumstances that require additional support and coordination efforts. MDCH 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. Additional limitations on the amount, frequency, or duration of services are identified in Attachment L of the contract between the PAHP or CIL and MDCH.

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
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 shall 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 therapy 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.

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 COMMUNITY HEALTH
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 plan of service 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 environmental accessibility adaptations 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 shall 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 environmental accessibility adaptation service, waiver agencies may use MI Choice funds for labor costs and to purchase materials used to complete the modifications to prevent or remedy a sub-standard condition or safety hazard. The direct service provider shall 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 environmental accessibility adaptations for rental property without close examination of the rental agreement and the landlord'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 shall 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 shall document approval of all environmental accessibility adaptations in the participant's record. This documentation shall minimally include dates, tasks performed, materials used, and cost.

12. The direct service provider shall check each domicile for compliance with local building codes. The waiver agency may not approve repairs, modifications, or adaptations to a condemned structure.

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

14. 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.

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

16. 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

17. Within fourteen calendar days or ten working days of completion, each waiver agency shall 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 Environmental Accessibility Adaptations 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 shall 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 shall 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 shall 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 COMMUNITY HEALTH
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 plan of service, 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 plan of service. 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 K 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 shall 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 COMMUNITY HEALTH
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 plan of service, 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 plan of care 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 plan of service.

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 COMMUNITY HEALTH
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 recommended dietary allowance (RDA) for the age group as established by the Food and Nutritional Board of the National Research Council of the National Academy of Sciences. Allowances shall be made in HDMs for specialized or therapeutic diets as indicated in the participant's plan of service. A Home Delivered Meal 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 person for whom the MI Choice waiver program is purchasing home delivered meals. Waiver agencies authorize MI Choice payment of meals for their participants.

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 waiver agency must have written eligibility criteria for persons receiving home delivered meals through the waiver program which include, at a minimum:

   a. The participant must be unable to obtain food or prepare complete meals.
   b. The participant does not have an adult living at the same residence or in the vicinity that is able and willing to prepare all meals.
   c. The participant does not have a paid caregiver that is able and willing to prepare meals for the participant.
   d. The provider can appropriately meet the participant's special dietary needs and the meals available would not jeopardize the health of the individual.
   e. The participant must be able to feed himself/herself.
   f. The participant must agree to be home when meals are delivered, or contact the program when absence is unavoidable.

3. Federal regulations prohibit the MI Choice program from providing three meals per day to waiver participants. Providers shall 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 shall identify and/or document in the case record, the usual source of all meals for the participant that are not provided by the program.

4. Each home delivered meals provider shall have the capacity to provide three meals per day, which together meet the Dietary Reference Intakes (DRI) and recommended dietary allowances (RDA) as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences. Each provider shall have meals available at least five days per week.

5. The program may offer liquid meals to participants when ordered by a physician. The regional dietitian must approve all liquid meal products used by the provider. The provider or supports coordinator shall provide instruction to the participant, and/or 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 shall 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 plan of care for participant receiving liquid meals in consultation with the participant's physician.

6. 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 shall be billed accordingly.

7. The provider may furnish frozen meals when feasible and appropriate. When furnishing frozen meals, the following standards must be met:

    a. The supports coordinator or provider shall verify and maintain records that indicate each participant receiving frozen meals has and maintains the ability to store and handle frozen meals properly.
    b. The provider may only provide frozen meals in situations where it is not logistically feasible to provide the participant with a hot meal, with the exception of holidays, weekends, or emergencies.
    c. Providers shall not furnish more than a two-week supply of frozen meals to a participant during one home delivery visit.

8. Each provider shall develop and have available written plans for continuing services in emergency situations such as short term natural disasters (e.g., snow and/or ice storms), loss of power, physical plant malfunctions, etc. The provider shall train staff and volunteers on procedures to follow in the event of severe weather or natural disasters and the county emergency plan.

General Requirements

1. Providers may present hot, cold, frozen or shelf-stable meals that conform to the following meal pattern:

Meal Requirements	Servings per meal	Notations
Bread or Bread Alternate	2 servings of bread, rice, pasta, or cereal. A starchy vegetable may replace one bread serving.	Encourage whole grains.
Vegetable	2 servings: 1 serving = ½ cup or equivalent measure	Fresh, frozen, or canned and prepared without added sodium. Focus on deep colored and dark green leafy vegetables. Cooked dried beans or peas are a good fiber source.
Fruit	1 serving: ½ cup or equivalent measure (may serve an additional fruit instead of a vegetable)	Fresh, frozen, canned, or dried. Deep colored fruits and good sources of Vitamin C are encouraged daily.
Milk or Milk Alternate	1 serving: 1 cup or equivalent measure	Encourage low-fat or skim milk, buttermilk, yogurt or cottage cheese.
Meat or Meat Alternate	1 serving: 2-3 oz. or equivalent measure	Encourage lean and low-fat meats and cheeses. Dried beans and peas are a good choice. Peanut butter, cottage cheese, tofu, and eggs also qualify.
Fats	1 serving: 1 teaspoon or equivalent measure	Select choices that are good sources of mono-and poly-unsaturated fats. Limit total fat to no more than 30% of total daily calories. Each week's meals shall contain no more than 25 grams average total fat.
Dessert	Optional	Choose nutrient dense desserts such as fruits, whole grain quick breads, puddings with limited fats and sugars. Limit high calorie desserts such as pies, cakes, cookies etc.
Sodium	No more than 1200 mg per meal average weekly total.	Select and prepare foods with less salt or sodium and use salt-free seasonings.
Fiber	3 choices out of a 5 day week high fiber	Choose whole grains, fruits and vegetables

2. In addition to the meal pattern above, servings shall conform to the following:

Bread or Bread Alternate

- 1 small 2 ounce muffin
- 2” cube cornbread
- 1 biscuit, 2.5” diameter
- 1 waffle, 7” diameter
- 1 slice French toast
- ½ English muffin
- 1 tortilla, 6” diameter
- 2 pancakes, 4” diameter
- ½ bagel
- 1 small sandwich bun
- ½ cup cooked cereal, grits, barley, bulgur or masa
- 4-6 crackers
- ½ large sandwich bun
- ¾ cup ready to eat cereal
- ¼ cup granola
- 2 graham cracker squares
- ½ cup bread dressing or stuffing
- ½ cup pasta, noodles, rice

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

Vegetables

- A serving of vegetable (including dried beans, peas, and lentils) is generally ½ cup cooked or raw vegetable; ¾ cup 100% vegetable juice; or, 1 cup raw leafy vegetable. For pre-packed 100% vegetable juices, a ½ cup juice pack may be counted as a serving if a ¾ cup pre-packed serving is not available.
- Fresh or frozen vegetables are preferred. Canned vegetables are acceptable but may be high in sodium.
- Vegetables as a primary ingredient in soups, stews, casseroles or other combination dishes should total ½ cup per serving.
- Starchy vegetables, such as potatoes, sweet potatoes, corn, yams, or plantains, may replace one of the two bread servings.

Fruits

- A serving of fruit is generally a medium apple, banana, orange, or pear; ½ cup chopped, cooked, or canned fruit; or ¾ cup 100% fruit juice. For pre-packed 100% fruit juices, a ½ cup juice pack may be counted as a serving if a ¾ cup pre-packed serving is not available.
- Fresh, frozen, or canned fruit should be preferably packed in juice, light syrup or without sugar.

Milk or Milk Alternates

- One cup low-fat, skim, whole, buttermilk, low-fat chocolate, or lactose-free milk fortified with Vitamins A and D should be used. Low fat or skim milk is recommended for the general population. Powdered dry milk (1/3 cup) or evaporated milk (1/2 cup) may be served as part of a home delivered meal.

- Milk alternates for the equivalent of one cup of milk include:
  - 1 cup yogurt
  - 1 ½ cups cottage cheese
  - 8 ounces tofu (processed with calcium salt)
  - 8 ounces calcium fortified soy milk
  - 1+½ ounces natural or 2 ounces processed cheese

Meat or Meat Alternates

- Two to three ounces of cooked meat or meat alternate should generally be provided for the lunch or supper meal. Meat serving weight is the edible portion, not including skin, bone, or coating.

  The following are equivalent to 1 ounce of meat
  - 1 large egg
  - 1 ounce cheese (nutritionally equivalent measure of pasteurized process cheese, cheese food, cheese spread, or other cheese product). It is best to choose low-fat cheese such as mozzarella, feta, ricotta, etc.
  - ½ cup cooked dried beans, peas or lentils (separate from vegetable serving)
  - 2 tablespoons peanut butter or 1/3 cup nuts
  - ¼ cup cottage cheese
  - ½ cup or 4 ounces tofu
  - ¼ cup tempeh

- A one ounce serving or equivalent portion of meat, poultry, or fish may be served in combination with other high protein foods.
- Except to meet cultural and/or religious preferences and for emergency meals, avoid serving dried beans, peas, lentils, peanut butter or peanuts, and tofu for consecutive meals or on consecutive days.
- Imitation cheese (which the Food and Drug Administration defines as one not meeting nutritional equivalency requirements for the natural, non-imitation product) cannot be served as meat alternates.
- To limit the sodium content of the meals, serve cured and processed meats (e.g., ham, smoked or Polish sausage, corned beef, wieners, luncheon meats, dried beef) no more than once a week.

Accompaniments

Include traditional meal accompaniments as appropriate, e.g., condiments, spreads, and garnishes. Examples include: mustard and/or mayonnaise with a meat sandwich; tartar sauce with fish; salad dressing with tossed salad; margarine with bread or rolls. Whenever feasible, provide reduced 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, and cholesterol.

Desserts

Serving a dessert is optional. Healthier desserts generally include fruit, low-fat puddings, whole grains, low-fat products, and limited sugar items such as quick breads (banana or pumpkin bread). Fresh, frozen, or canned fruits packed in their own juice are encouraged as a dessert item in addition to the serving of fruit provided as part of the meal.

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.

Vegetarian Meals
Vegetarian meals can be served and should follow the principle of complementary proteins, where proteins from plant sources (legumes such as cooked dried beans and peas) are combined with grains (rice, breads, pasta) at the same meal. Vegetarian meals are a good opportunity to provide variety to menus and highlight the many ethnic food traditions found in Michigan.

Breakfast Meals
A breakfast meal may contain three fruit servings and no vegetable as an option to the required meal plan.

3. Each provider shall utilize a menu development process that prioritizes healthy choices and creativity and minimally includes:

    a. Use of written, standardized recipes.
    b. Consultation with the regional dietitian during the menu development process and use of cycle menus for cost containment and/or convenience are encouraged, but not required.
    c. Provision for review and approval of all menus by the regional dietitian who must be a registered dietitian, or an individual who is dietitian-registration eligible.
    d. The provision of information on the nutrition content of menus upon request.
    e. The provision, where feasible and appropriate, of modified diet menus that considers participant choice, health, religious and ethnic diet preferences.
    f. A record of the menu actually served each day. The provider shall maintain this record for each fiscal year's operation.
    g. Written procedures for revising menus after approval.

4. The provider must operate according to current provisions of the Michigan Food Code. Local Health Departments establish minimum food safety standards. Each provider must keep copy of the Michigan Food Code available for reference. MDCH encourages providers to monitor food safety alerts.

    Each provider that operates a kitchen for food production, shall have at least one key staff person (manager, cook or lead food handler) complete a Food Service Manager Certification Training Program approved by the Michigan Department of Agriculture. MDCH prefers, but does not require a trained and certified staff member at satellite serving and packing sites.

    The provider shall feasibly minimize the time between the end of preparation of food and home delivery to the participant. The provider shall prepare, hold, and serve food at safe temperatures. The provider shall develop in conjunction with the respective local Health Department acceptable documentation requirements for food safety procedures.

    The participant is responsible for the safety of food after it has been served or when it has been removed from the meal site.

The provider must use foodstuff from commercial sources that comply with the Michigan Food Code. Unacceptable items include: home canned or preserved foods; foods cooked or prepared in an individual's home kitchen; meat from any animal not killed by a licensed facility; any wild game taken by hunters; fresh or frozen fish donated by sport fishers; raw seafood or eggs; and, any un-pasteurized products (i.e., dairy, juices and honey).

The provider may use contributed foodstuff only when they meet the same standards of quality, sanitation, and safety as apply to food stuffs purchased from commercial sources. Acceptable contributed foodstuffs include fresh fruits and vegetables, and wild game from a licensed farm processed within two hours of killing by a licensed processor.

5. Each provider shall use standardized portion control procedures to ensure that each meal served is uniform and satisfies meal pattern requirements. The provider may alter standard portions at the request of a participant for less than the standard serving of an item or if a participant refuses an item. The provider shall not serve less than standard portions to "stretch" available food to serve additional persons.

6. Each provider shall implement procedures designed to minimize waste of food (leftovers/uneaten meals).

7. Each provider shall use an adequate food cost and inventory system at each food preparation facility. The provider shall base the inventory control on the first-in/first-out (FIFO) method and conform to generally-accepted accounting principles. The system shall have the ability to provide daily food costs, inventory control records, and monthly compilation of daily food costs. Each provider have the ability to calculate the component costs of each meal provided according to the following categories:

   a. Raw Food — All costs of acquiring foodstuff to be used in the program.
   b. Labor — Food Service Operations: all expenditures for salaries and wages, including valuation of volunteer hours, for personnel involved in food preparation, cooking, delivery, serving, and cleaning of meal sites, equipment and kitchens;
      Project Manager: all expenses for salary wages for persons involved in project management.
   c. Equipment — All expenditures for purchase and maintenance of items with a useful life of more than one year or with an acquisition cost of greater than $5,000.
   d. Supplies — All expenditures for items with a useful life of less than one year and an acquisition cost of less than $5,000.
   e. Utilities — All expenditures for gas, electricity, water, sewer, waste disposal, etc.
   f. Other — Expenditures for all other items that do not belong in any of the above categories (e.g. rent, insurance, fuel etc.) to be identified and itemized.

   If a provider operates more than one meal/feeding program (congregate, HDM, waiver, catering, etc.), the provider shall accurately distribute costs among the respective meal

programs. The provider shall only charge costs directly related to a specific program to that program.

8. Each provider shall provide or arrange for monthly nutrition education appropriate to home delivered meals participants. Topics shall include, but are not limited to, food, nutrition, wellness issues, consumerism, and health. The regional dietitian must approve all nutrition education materials and presenters.

9. MDCH encourages each meal provider to use volunteers, as feasible, in program operations.

10. Each provider shall develop and utilize a system for documenting meals served. Obtaining daily signatures of participants receiving meals is the most acceptable method of documenting meals. Other acceptable methods may include maintaining a daily or weekly route sheet signed by the driver which identifies the participant's name, address, and number of meals served to them each day.

11. Each provider shall carry product liability insurance sufficient to cover its operation.

12. The waiver agency shall take steps to inform participants about local, State, and Federal food assistance programs and assist participants to obtain such benefits.

13. Staff and volunteers of each provider shall receive in-service training at least twice each fiscal year which is specifically designed to increase their knowledge and understanding of the program and to improve their skills at tasks preformed in the provision of service. The provider shall maintain records that identify the dates of training, topics covered, and persons attending.

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 shall not constitute a full nutritional regimen.

4. Providers shall not solicit donations from waiver participants.

5. Providers shall not use waiver funds to purchase dietary supplements.

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
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 plan of service. 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), and does not replace State Plan services. MI Choice transportation services cannot be substituted for the transportation services that MDCH is obligated to provide under the listed citations. Such transportation, when provided for medical purposes, is not reimbursable through MI Choice. When the costs of transportation are included in the provider rate for another waiver service (e.g., Adult Day Health), 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 mile 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 use waiver funds to pay for the costs of non-medical transportation for waiver participants. Whenever possible, the waiver agency shall utilize family, neighbors, friends, or community agencies that can provide this service without charge.

3. Direct service providers shall be a centrally organized transportation company or agency. The provider may provide 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 who transport participants in their 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 shall include a passenger assistance component.

4. 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.

5. All paid drivers for transportation providers supported entirely or in part by MI Choice funds shall be physically capable and willing to assist persons requiring help to and from and to get in and out of vehicles. The provider shall offer such assistance unless expressly prohibited by either a labor contract or insurance policy.

6. The provider shall 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.

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

8. Each waiver agency and/or provider shall 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, Department of Human Services, Department of Community Health, 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.”

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 shall 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 shall 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 waiver funds to purchase or lease vehicles for providing transportation services to waiver participants.

4. Waiver agencies shall 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 COMMUNITY HEALTH
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 shall 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 shall 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 cannot be self-administered (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 Community Living Supports for participants choosing the self-determination option, waiver agencies must comply with items 2, 3, 4, and 5, 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.

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 COMMUNITY HEALTH
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. Installation, upkeep and maintenance of devices and systems are also provided.
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

<u>Minimum Standards for Traditional Service Delivery</u>

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.
    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 of time 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.

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
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 plan of service. 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 plan of service 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 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 shall determine the length and duration of services provided.

4. The direct service provider shall 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 shall 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 shall 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/or direct service provider shall 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 shall 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 www.michigan.gov/mdch.

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 MDCH.

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 COMMUNITY HEALTH
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. Participant's 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 shall 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 and/or participant's caregiver, the waiver agency or direct service provider shall determine an emergency notification plan for each participant, pursuant to each visit.

7. Each direct service provider shall establish written procedures that govern the assistance given by staff to participants with self-medication. These procedures shall be reviewed by a consulting pharmacist, physician, or registered nurse and shall 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 shall 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 shall 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 shall 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 shall 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 shall 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. Participant's 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. MDCH 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 plan of service 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. Respite services cannot be scheduled on a daily basis.

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

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

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
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

<u>Minimum Standards for Traditional Service Delivery</u>

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 the 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.

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 care support services the participant needs.

7. Each direct service provider shall 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 and/or participant's caregiver, the waiver agency and/or direct service provider shall determine an emergency notification plan for each participant, pursuant to each visit.

8. Each direct service provider shall establish written procedures to govern the assistance given by staff to participants with self-medications. These procedures shall be reviewed by a consulting pharmacist, physician, or registered nurse and shall 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 shall 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 shall employ a professionally qualified program director that directly supervises program staff.

Limitations

1. MDCH 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 plan of service 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 shall not authorize MI Choice waiver payment for more than 30 days of out of home respite service per calendar year.

5. Respite services cannot be continually scheduled on a daily basis. Out of home respite may be scheduled for several days in a row, depending upon the needs of the participant and the participant's caregivers.

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

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

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
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 plan of service. All items shall 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 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 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 and/or direct service provider shall 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, and/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 shall not pay for the medication.

8. The waiver agency may provide liquid nutritional supplements as a specialized medical supply. The participant's physician 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 renews the order for liquid nutritional supplements every six months.

9. The waiver agency shall not authorize MI Choice payment for herbal remedies and/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 shall 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 COMMUNITY HEALTH
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 plan of service. 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. Conducting the initial and subsequent Nursing Facility Level of Care Determinations per state policy.

   b. Conducting the initial assessment and periodic reassessments.

   c. Facilitating a person-centered planning process 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. Developing a plan of service using the person-centered planning process, including revisions to the plan of service at the participant's initiation or as changes in the participant's circumstances may warrant.

   e. Referral to and coordination 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. Monitoring of MI Choice waiver services and other services and supports necessary for achievement of the participant's goals. Monitoring includes opportunities for the participant to evaluate the quality of services received and whether those services achieved desired outcomes. This activity includes the participant and other key sources of information as determined by the participant.

g. Providing 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. Providing advocacy in support of the participant's access to benefits, assuring the participant's rights as a program beneficiary, and supporting the participant's decisions.

i. Maintaining 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 MDCH.

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 I of the contract between the waiver agency and MDCH.

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 COMMUNITY HEALTH
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 plan of service. 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

<u>Minimum Standards for Traditional Service Delivery</u>

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 plan of service. 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 COMMUNITY HEALTH
Minimum Operating Standards for MI Choice Waiver Program Services

DEFINITION OF TERMS

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.

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 (HCBS/ED) Medicaid waiver program.

MDCH: The Michigan Department of Community Health.

MMIS: The Medicaid Management Information System, the software MDCH 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 MDCH.

Participant: A person enrolled in the MI Choice program.

Person-Centered Planning: A highly individualized process designed to respond to the expressed needs/desires of the individual.

Plan of Service: 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.

Service Plan: A list of the planned interventions (i.e. services) provided to a participant and paid for with MI Choice waiver funds.

Waiver Agency: An entity under contract with MDCH to administer the MI Choice Waiver program in a specific PSA.